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At this time, no published information has been identified by the author that would support the research of increasing a military healthcare facility's services to support a beneficiary population that is significantly increasing in size yet with the same physical support structure. The purpose of this research is to develop a strategic plan to determine an optimal "mix" of services for Irwin Army Community Hospital (IACH). A comparison of services provided by similar facilities will serve as the basis for analyzing likely capability requirements while forecasting tools will serve to estimate likely demand for these services. The expected results of the study will provide a set of rank-ordered alternatives for consideration by the leadership of IACH, alternatives that comprise future business case analysis' (BCA) and that will meet the increasing beneficiary, in support the facilities new strategic plan.

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Strategic Planning for Irwin Army Community Hospital:
The Assessment and Implementation of Services,
in Order to
Meet Fort Riley's Increasing Population

Graduate Management Project

Submitted to Chaplain (Major) Joseph R. Jeffries, M/DIV, MA

In partial fulfillment of the requirements for Degrees in Health
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Abstract

At this time, no published information has been identified by the author that would support the research of increasing a military healthcare facility's services to support a beneficiary population that is significantly increasing in size yet with the same physical support structure. The purpose of this research is to develop a strategic plan to determine an optimal "mix" of services for Irwin Army Community Hospital (IACH). A comparison of services provided by similar facilities will serve as the basis for analyzing likely capability requirements while forecasting tools will serve to estimate likely demand for these services. The expected results of the study will provide a set of rank-ordered alternatives for consideration by the leadership of IACH, alternatives that comprise future business case analysis' (BCA) and that will meet the increasing beneficiary, in support the facilities new strategic plan.

Disclaimer

The opinions or assertions contained herein are the views of the author and do not reflect the official policy or position of the Department of the Army, Department of Defense, U.S. Government or Baylor University.

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Executive Summary

Irwin Army Community Hospital (IACH) offers healthcare services to the military service members and their families, both active and retired, assigned to Fort Riley, Kansas, and the surrounding communities. This is achieved through a multitude of services provided by the main hospital, two satellite troop medical clinics and a family member primary care clinic. At the current population and with the recent inception of the Warrior Transition Battalion (WTB), the staff and level of services provided are over capacity. Coupled with the additional growth of beneficiaries, based on the 2005 Base Realignment and Closure (BRAC) and Grow the Army (GTA) initiatives, the services provided and staff required to support the population requires review and modification to provide the proper amount of healthcare to the population.

Mission

To provide and manage the healthcare of Soldiers, military families and retirees; to support the readiness and deployment of a medically protected force; and empower and value our staff while achieving effective practices and meeting diverse future requirements (FR MEDDAC 10-132, 2007).

Vision

To provide state of the art care for America's Big Red One community (FR MEDDAC 10-132, 2007).

Introduction

Background

Fort Riley is located in eastern Kansas and considered to be a rural area. It was established in 1853 as a military post to protect the movement of people and trade over the Oregon-California and Santa Fe trails. Fort Riley is named in honor of Major General Bennett C. Riley, who led the first military escort along the Santa Fe Trail. Fort Riley has always had an important role in the defense of our nation and the training of our soldiers (Fort Riley Museum, 2007). In July 1955, 1st Infantry Division rotated from duties in Europe to Fort Riley until 1965, when the Vietnam conflict called for 1st Division to leave its home. This deployment lasted until 1970 and after five years of combat, the division returned to Fort Riley. The unit maintained residence at Fort Riley until 1996, when the division was moved to Europe in support of Post-Cold War Strategies. A brigade of the Big Red One remained at the post along with a brigade of the 1st Armored Division and the 937th Engineer Group (Fort Riley Museum, 2007). The 1st Infantry Division headquarters returned to Fort Riley on August 1, 2006, under the 2005 Base Realignment and Closure Act (BRAC).

Construction on the current Irwin Army Community Hospital began on July 19, 1955. At the time of dedication, Irwin Army Community Hospital boasted the latest medical technology of the

day. The new hospital was dedicated on February 7, 1958, and named Irwin Army Hospital in honor of Brigadier General Bernard John Dowling Irwin, "The Fighting Doctor", who was awarded the Congressional Medal of Honor for distinguished gallantry in action during an engagement with the Chiricahua Indians near Apache Pass Arizona in February 1861. In August 1975, construction began for a new outpatient clinic wing. Construction was completed in June 1978, at a cost of \$21.108 million. Currently, 17 of the 23 outpatient clinics at IACH are housed in the outpatient wing (Fort Riley Museum, 2007).

Although originally established as a 250 bed inpatient facility, the number of beds along with other services was reduced due to previous BRAC initiatives that reduced the installation troop strength. Currently, IACH houses 44 inpatient beds and a variety of provider services. With the 2005 BRAC Act increasing the troop strength over the next six fiscal years, the hospital is constantly assessing the needs of the population coupled with the physical facilities available in order to provide care based on patients needs. This is accomplished through a multifaceted approach of facility renovation & utilization, healthcare services assessment & manipulation and purchased care of services not provided by IACH, from the local network. The remote location of IACH requires services be purchased from not only the local network, but also facilities able to provide

needed services within the state as well as other Military Treatment Facilities (MTF) outside of Kansas.

Junction City (pop.16,106) and Manhattan (pop. 50,373) are the two largest cities directly outside of the installation with any major type of healthcare support services. Other cities within a 150 mile radius of Fort Riley that have a direct impact on services provided to IACH beneficiaries are Topeka (pop. 121,412), Salina (pop. 46,140), Wichita (pop. 357,698), Kansas City, KS and Kansas City, MO (pop. 590,010).

Problem Statement

The rapidly growing population of Fort Riley, KS, is presenting Irwin Army Community Hospital with a daunting challenge: what services to add, when, where and in what capacity. Less than 18 months ago, IACH supported an eligible beneficiary population of roughly 23,000-24,000. Upon end-state for population growth, around fiscal year (FY) 13, the beneficiary population for Fort Riley will reach approximately 56,000. The enrollee population increase by fiscal year can be seen in Figure 1.

Purpose

The purpose of this research is to develop a strategic plan to determine an optimal "mix" of services for Irwin Army Community Hospital (IACH). A comparison of services provided by similar facilities will serve as the basis for analyzing likely

capability requirements while forecasting tools will serve to estimate likely demand for these services. The expected results of the study will provide a set of rank-ordered alternatives for consideration by the leadership of IACH. Such alternatives will form the foundation for future business plans and ultimately support the facility's new long range focus and goals.

Requirements for the reorganization of the hospital, family clinic and two troop medical clinics (TMC) both physically and in terms of services provided, will need to be estimated based off of purchased care and demand of services. Dependant on the actual outcome of the identified need and time of implementation, interim solutions must be implemented in order to provide services and support to the beneficiaries of Fort Riley. These solutions may include referral of unavailable or overextended services to the local community's healthcare providers and facilities. Prioritization of what can be referred and what should be maintained within the facility will be analyzed.

Literature Review

"In the past year, the Military Health System(MHS) took several additional important steps in our multi-year transformation that will prepare our military forces and our military medical forces for the future. Our focus has been to develop greater joint capabilities and joint operations. I will outline a number of these initiatives today.

We guide all of our efforts through a vision of jointness, interoperability, greater efficiency, improved outcomes, and world-class education, research, and medical care. We have refined our MHS Strategic Plan, itself a superb road map, to provide a long-term perspective on the critical imperatives that will determine our success for the years ahead. We shaped our strategic plan with the recommendations contained in the 2006 Quadrennial Defense Review (QDR), Medical Readiness Review (MRR), and the Base Realignment and Closure Commission (BRAC) reports.

This plan - developed in concert with the Surgeons General, the Joint Staff and our line leaders - recognizes that our stakeholders, including this congressional body representing the American people, expect the following outcomes from the resources invested in military medicine:

- A fit, healthy and protected force
- Reduced death, injuries and diseases during military operations, and superior follow-up care and seamless transition with the VA
- Satisfied beneficiaries
- Creation of healthy communities
- Effective management of healthcare costs

Our internal measures and those of independent, external organizations show we are excelling in our mission. Yet, we are hardly complacent. We recognize that we must build upon our successes to sustain this global, unique military medical system."(Winkenwerder, 2007)

What is Strategy?

Even in the prevailing orthodoxy of strategy theory there is a striking lack of agreement of an operational definition of what makes a strategy become a strategy (Haugstad, 1999). The word "strategy" has long been affiliated with militaries and is

derived from the Greek word "strategos", literally meaning "general of the army". From these military roots, strategic planning has always been aimed at the "big picture" (Blackerby, 1994). With a lack of a commonly agreed upon definition, most authors will create their own definitions for the word strategy. This lack of a commonly acceptable definition and self defining is best illustrated by Haugstad through the following depictions of some of the leading scholars own definitions:

James Quinn (1998) defines strategy as:

(...) the pattern or plan that integrates an organization's major goals, policies and action sequences into a cohesive whole. A well-formed strategy helps to marshal and allocate an organization's resources into a unique and viable posture based on its relative internal competencies and shortcomings, anticipated changes in the environment and contingent moves by intelligent opponents.

Kenneth Andrews (1998) writes:

Corporate strategy is the pattern of decisions in a company that determines and reveals its objectives, purposes or goals, produces the principal policies and plans for achieving those goals, and defines the range of business the company is to pursue, the kind of economic and human contribution it intends to make to its shareholders, employees, customers and communities.

Hax and Majluf (1996) point out that strategy is a multiheaded monster and states nine different dimensions of strategy:

Strategy

1. determines and reveals the organizational purpose in terms of long-term objectives, action programs, and resource allocation priorities;
2. selects the businesses the organization is in, or is to be in;
3. attempts to achieve a long term, sustainable advantage in each of its businesses by responding appropriately to the opportunities and threats in the firm's environment, and the strengths and weaknesses of the organization;
4. identifies the distinct managerial tasks at the corporate, business and functional levels;
5. is a coherent, unifying, and integrative pattern of decisions;
6. defines the nature of the economic and non-economic contributions it intends to make to its stakeholders;
7. is an expression of the strategic intent of the organization;
8. is aimed at developing and nurturing the core competencies of the firm;
9. is a means for investing selectively in tangible and intangible resources to develop the capabilities that assures a

sustainable competitive advantage.

Through this sampling of differing definitions, one might say that with so many interpretations, the actual definition of the word strategy will be so encompassing that it will lose its specific meaning. In an early attempt to control the multitude of definitions, a study was conducted by Schendel and Hofer in 1978 and has one of the most widely accepted results in this area. This study was based on different definitions and concepts of strategy and resulted in a composite definition. This combined definition of strategy was built around four components. The first component of the combined definition is scope. Scope was defined in terms of product/market matches and geographic territories. The second component was resource deployments and distinctive competences. Next was the component of competitive advantages. The final component for the composite definition was the synergy of the three organizational levels: (1) corporate, (2) business, and (3) functional (Schendel & Hofer, 1979). Though seen by the date of the Schendel and Hofer study, and previously referenced strategy definition dates, the definition was widely interpreted, and as with most things, the definition continues to change as the theory of strategy evolves.

Strategy Theory

Strategy Theory is a diverse multidisciplinary academic field with competing schools of thought based on partly incommensurable basic assumptions, including disagreement about what strategy theory should seek to explain (Haugstad, 1999). Following the end of World War II, top executives were concerned with the general direction and long-term policy of their enterprises (Mele & Guillen, 2006). This prompted more business schools to require "corporate policy" within their business curriculum and encouraged systematical thinking about strategy and the theory of it. Three such theories of strategy are the Classical Approach, Alternative and Resource Based Theory (RBT).

The Classical Approach first emerged in the academic field in the early sixties. This was accomplished through the publication of three books; *Strategy and Structure: Chapters in the History of the Industrial Enterprise* by A. Chandler Jr. (1962), *Business Policy: Text and Cases* by E.P. Learned, C.R. Christensen (1965), K.R. Andrews and W.D. Guth (1969), and *Corporate Strategy* by I. Ansoff (1965). The first two books mentioned and their respective authors are credited with forming the "design" school while Ansoff is recognized in founding the "planning" school. With the "position" school created by Porter in 1980, these three schools form the foundation of the classical approach. One of the common beliefs these schools

share is that of "a positivistic view of knowledge". Haugstad (1999) describes this as; the CEO is recognized as having sole responsibility for the strategy formation; centralized and planned processes produce full-blown and explicit strategies; and a notable ignorance of the complexity inside of organizations. Some differences between the schools are best illustrated in their process. The "design" school consists of an informal process that is centralized, while the "planning" school seeks to have a formal process within the organization. Since their inception, the impacts of these three schools on businesses have been immense.

The Alternative Strategy Theory emphasizes the learning process, and is in contrast to that of the classical approach. Part of the academic community said that the formation of strategy is a result of an expressed need in an expedient manner or even just simply learned over time and slowly pulled together. This approach to the theory of strategy puts importance in the learning and understanding of the organization and recognizes their value within the overall strategy.

Resource Based Theory (RBT) uses resources as a unit of analysis. RBT defines resources as both tangible and intangible assets that a firm uses to choose and implement in its strategies. RBT strategy is based on a firm's theory of how it is going to gain and sustain competitive advantage, which is

done through the business creating more economic value than that of its competitors. The primary goal of this theory is to efficiently meet the customer's needs, which is done through keeping the firm standardized and globally competitive. Currently 70% of published articles in strategic management journals over the last five years build on RBT (Barney, 2005).

What is Strategic Management?

Schendel and Hofer (1979) define strategic management as a process that deals with the entrepreneurial work of the organization, with organizational renewal and growth, and more particularly, with developing and utilizing the strategy which is to guide the organization's operations. According to Arthur Goldsmith of The University of Massachusetts at Boston, strategic management is meant to be useful for managers and tends to see organizations from the top downward, from the manager's point of view. The four main teachings are:

First, look to the future. Know what markets you are in and want to be in.

Second, pay ongoing attention to external factors—technological, economic, political, and social—that affects the organization's ability to get where it wants to go.

Third, establish and keep a match among those external factors and internal organization variables: finances, employees, special skills, and so on.

Fourth, strategic management is interactive. It is not something that can be done at the front end of an operation and then dropped; it entails feedback and learning (Goldsmith, 1995).

The basic components of strategic management are formulation and implementation.

Strategy formulation involves conducting various types of analysis, to include: situation, self-evaluation and competitor. Competitor analysis needs to be done both internally and externally as well as on the micro and macro-environmental levels. Simultaneously conducted during the assessment, the objectives are set. The objectives include mission and vision statements, corporate objectives, strategic business objectives and tactical objectives. The results of the objectives and the situation analysis assist in the strategic plan. Strategic planning details how to achieve the objectives and is discussed further in the subsequent section.

Strategy implementation involves the proper allocation of resources, to include financial, personnel, time and technology. The proper establishment and management of teams, and their respective assignment of tasks, is imperative to the implementation of a strategy. The management of the process is key to the strategy's implementation. This includes monitoring results, comparing against benchmarks and best practices,

evaluating the efficacy and efficiency of the process, controlling for variances, and making adjustments to the process as necessary.

Strategic Planning

Of the many parts of strategic management, strategic planning is only one. The strategic plan serves as the hub of strategic management around which all other management plans and control systems (budget, information, marketing, compensation, and organizational structure), are developed, integrated, and supported (Gray, 1986). Gray states that a strategic plan involves the allocation of resources to programmed activities which support the achievement of business goals in a dynamic and competitive environment. Whereas, Kropf and Greenberg (1984) describe it as the process of making and implementing decisions concerning the use of resources to achieve an organization's goals and to fulfill its mission. No matter the definition given for strategic planning, there is a reoccurring theme—planning is future oriented (Crook, 1990).

Strategic planning is critical to the continued success of any organization, yet fewer than half of the executives that responded to a new online survey conducted by *The McKinsey Quarterly* say that they are satisfied with their company's approach to strategy planning (Dye, 2006). This survey received 796 responses from executives of international organizations

that had revenues of at least \$500 million. The main issue that respondents voiced is "Who makes the strategic decision?" Over half of the responses stated that a small group of senior managers are the exclusive decision makers. The survey also noted executive's dissatisfaction with the failure to the launch of plans and that of plans that are launched but not monitored and/or improved. This survey's results can assist businesses in learning from other organization's mistakes, and the information gained from these issues can lend itself to the establishment of a firm business plan from the start.

Population-Based Data

The purpose for the population-based data, as described in the U.S. Public Health Service *Healthy People 2000* report (U.S. Department of Health and Human Services, 1990) and by Manderscheid and Henderson (1995), is to allow for assessment of the overall health status of the general community population, so that adequate planning for services of persons in need can be accomplished and overall system performance can be monitored. This overall health status assessment is an integral part in determining population based healthcare.

Halpern and Boulter (2000), describe population-based care in terms of panels of health plan members or patients associated with a physician, practice or delivery system; this is distinct from the public health perspective of population being all

residents of a geographic community or region. In the present-day environment, physicians are responsible for panels of patients according to their health plan affiliation. Strategies and tools for addressing these panels in their entirety include: an epidemiologic assessment to learn about the group's unique health characteristics and behaviors; risk appraisals to identify common issues and to develop individualized plans; development of or referral to broad based wellness, health promotion and disease prevention programs (e.g., exercise programs, seat-belt use); reminder calls or cards to subgroups regarding their appropriate screenings and preventive care measures (e.g., reminders to increase influenza vaccinations or mammography rates); and targeted measures to reach individuals who need but would not otherwise present for care (Halpern and Boulter, 2000).

Civilian Provider Forecasting

In 1933, a quantitative explanation of the physician workforce titled, "The Fundamentals of Good Medical Care" was released by a government established entity called the Committee on the Costs of Medical Care (CCMC). The resulting model was the basis for provider planning for the remainder of the 20th century. At the time of publication, Olin West MD was the Secretary of the American Medical Association and a member of the CCMC. Dr. West identified the outstanding problem

confronting medicine as, "The delivery of adequate, scientific medical service to all the people." This statement continues to bear relevance today. Seizing upon this statement, the CCMC attempted to define "adequate" by applying the principles of science (Cooper, et al., 2000). Cooper and associates go on to state that by focusing on "adequate," it limited its scope to "the essential services," since "medical care is a medical and not an economic concept" (a point that grossly underestimated the impact that the economy would have in the future). The CCMC concluded:

1. In the aggregate, good medical care in 1929 required exactly 283,131 hours of physician time. Assuming that each physician devoted 40 hours per week, 50 weeks per year to these tasks, "less than the present heroic working schedule," the system would need 140.5 physicians per 100,000 of population, a figure that was 10 percent greater than the existing supply.
2. That 18 percent of these physicians should be specialists in one of the 10 specialties then recognized.
3. A warning that, if the reader "expects to find here the finality of judgment and precision of detail, he is doomed to disappointment" (Cooper, et al., 2000)

In 1976, the Secretary of the Department of Health, Education and Welfare founded the Graduate Medical Education National Advisory Committee (GMENAC). Its mandate was to analyze

supply and specialty distribution of the physician workforce and suggest approaches to ensure an appropriate balance (Jewett, 2005). Using the model foundation used by the CCMC, GMENAC wanted to develop a model to further determine the required number of providers by each specialty. Like the CCMC's earlier model, GMENAC's was based on "dissecting the intricacies of the pluralistic health care system" from an epidemiologic perspective (Cooper, et al., 2000). GMENAC's recommendations were then to be used as a basis for federal policy to modify and control the numbers and kinds of GME training positions made available through federal funding (Jewett, 2005). The study was projected through the year 2000, and at the time of its projection, there would be a surplus of providers by approximately 145,000. Further recommendation based on GMENAC's forecast included: the reduction of medical school class sizes by 10%; restriction in the number of foreign medical school graduates allowed to practice in the United States; reorganizing potential graduates into specialty and primary care shortages and the stabilization of non-physician clinicians at present level (Jewett, 2005). Assessments were to be conducted at the local level in order to best meet the intent of the GMENAC findings. Ultimately, GMENAC's reports were widely criticized. Most criticism was a result of the perceived flaws in its mathematical modeling methods, and as a result, neither the

federal government nor the graduate medical education community accepted the recommendations (Snyder, et al., 2002).

Cooper, et al. (2002) examined the economic aspect of medical care. Measured adequacy of physician supply based on growth in the US economy (GDP) was conducted and analyzed using trend analysis (Cooper, et al., 2002). The study calculated non-physicians at a reduced weighted value for physicians and resulted in the projection of a shortage in specialty physicians. These results refuted previous findings of specialty provider surpluses. Though these new findings were disputed by many researchers of in the healthcare field, the methods used in this study have been duplicated by others conducting other types of workforce studies.

Military Provider Forecasting

The Automated Staffing Assessment Model (ASAM) is used by military treatment facilities to establish the proper staffing for its hospital based off the projected population that it will need care. This tool was in support of goal three, MEDCOM Strategic Plan, of the Army Surgeon General's balanced scorecard, "Align resources with population requirements."

Prior to the inception of ASAM in 1998, the use of benchmarking was first used by the AMEDD in 1993. The benchmarking methodology replaced the "one size fits all" mentality of the Joint Staffing Standard previously used by the

Military Health System (AMEDD, 1994). Benchmarking would focus on business aspects of a hospital to create a manpower model for the facility to properly staff itself. This new methodology was a direct result of a decrease in size of the military and the funding it received.

In a directive by the Commanding General for Army Manpower, all major commands were required to create workload based models in accordance with AR 570-4 (Manpower Management), and be validated and implemented by 30 June 1998 (AMEDD, 1998). The workload based model was to ensure mission accomplishment in the least costly form. In 1998, ASAM was fielded to AMEDD MTF's for use in projecting future staffing requirements. ASAM focused on all aspects and variances specific to the MTF and its mission. The program also resolved the inflation of requirements created by benchmarking and closely aligned requirements with workload in accordance with Department of Defense Directives (AMEDD, 1998). This workload based model reflected the future requirements with the minimum amount of available staffing and is highly accurate when honest workload is used. ASAM is HQDA-certified and received the 1998 Secretary of the Army Manpower and Force Management Award of Excellence for development and implementation of the model.

ASAM I and ASAM II used standards and formulas that were based on historical workload. Manpower requirements reflected

the work that had been done by the workforce that was present, not the work that should be done by the workforce needed to serve the patient population thus resulting in MTF commanders asking for a model based on projected patient population (ASAM Brief, 2002). This resulted in ASAM III.

Through ASAM III's basis of projected population and patient acuity, a supportive TDA can result. This new basis for ASAM III was a change from ASAM II, which used historical production based information to create future manpower requirements. Population data is gathered from the Defense Eligibility Enrollment System (DEERS) and the Standard Ambulatory Data Record (SADR). Figure 2 depicts the population model formula for primary care and Figure 3 depicts the population model formula for specialty care. The ASAM is revised annually and represents the projected needs of two years into the future. The main issue created by projections being done two years in advance is the lag time for proper future staffing levels to increase to meet current demand. When sudden changes to populations such as Base Realignment and Closure and Grow the Army initiatives are made, the ASAM model is not always responsive. ASAM calculations and results only account for the need of a certain specialty but do not determine whether it will be filled for the planned year. Any new specialties not required from the prior year are subject to the completion of a

business case analysis. In order to receive these newly required services, the facility must conduct a business case analysis for each new specialty and submit them to their regional medical command for approval. Provider per population ratios for FY06 can be seen in Figure 4 and the changes projected in FY13 can be reviewed in Figure 5.

Situational Analysis

To properly conduct situational analysis for a military hospital such as IACH, the area's healthcare network should be assessed as well as a similar military hospital (facility size, type of installation and beneficiary population). Fort Stewart's healthcare support system will be used as an external analysis for comparison of IACH's services. For local competitive analysis, Manhattan Surgical Center and Mercy Regional Health Center will be used for the city of Manhattan and Geary Community hospital will be used for Junction City. The internal analysis will be based on current services provided as of the end of Fiscal Year 07.

External Analysis

Fort Stewart is located next to Hinesville, GA. As of the 2000 Census, the City of Hinesville had a population of 29,296 and a county population of 58,925. There is one 36 bed hospital and one county health clinic that services this area. The next closest healthcare facility for Hinesville and Fort Stewart to

refer care to is 40 miles away in Savannah, GA. Savannah has a 2000 Census population of 131,510 and has a robust medical support system for its community.

Fort Stewart and Hunter Army Airfield are the home of the 3rd Infantry Division and 1st Battalion, 75th Ranger Regiment, and combine to be the Army's Premier Power Projection Platform on the Atlantic Coast. It is the largest, most effective and efficient armor training base east of the Mississippi River, covering 280,000 acres including parts of Liberty, Long, Tattnall, Evans and Bryan counties in southeast Georgia. Hunter Army Airfield is home to the Army's longest runway on the east coast (11,375 feet) and the Truscott Air Deployment Terminal. Together these assets are capable of deploying units such as the heavy, armored forces of the 3rd Infantry Division or the elite light fighters of the 1st Battalion, 75th Ranger Regiment (Fort Stewart website, 2007).

Fort Stewart, Georgia medical support structure gathered from winn.amedd.army.mil:

Winn Army Community Hospital opened in 1983, replacing the World War II era Fort Stewart Hospital which was a cluster of 70, one-story temporary wood buildings interconnected by ramps and corridors. Constructed in the latest military design of that time, the original building cost \$43 million and was furnished

with \$12 million of equipment. The four-story facility was named for Brigadier General Dean F. Winn, a U.S. Army Medical Corps' Orthopedic surgeon whose career spanned the years from 1914 to 1948. BG Winn commanded four Army hospitals during his distinctive career.

Services:

Behavioral Medicine

- Army Substance Abuse Program
- Behavioral Health Clinic
- Social Work Services

Emergency Medicine

Nutrition Care

Pathology

Pharmacy

Preventive Medicine

Primary Care

- Dermatology
- Educational and Developmental Intervention Services
- Family Practice
- Internal Medicine
- Pediatrics

Radiology

Surgery

- Eyes, Ears, Nose and Throat Clinic
- General Surgery & Urology
- Occupational Therapy
- Ophthalmology
- Optometry
- Orthopedics & Podiatry
- Physical Therapy

Women's Health

- Obstetric and Gynecology Service
- Midwifery/ Nurse Practitioner Service
- Clinical Support Service
- Pregnancy Acute Care Clinic
- Pregnancy Care and Education
- Gynecological Care and Education

Tuttle Army Health Clinic

Serves the Hunter Army Airfield area and is 40.5 miles from Winn Army Community Hospital.

Services:

Primary Care

Optometry

Behavioral Medicine
 Immunization Clinic
 Pediatrics
 Physical Exam
 Pharmacy
 Physical Therapy

Visiting OB/GYN
 Hearing Conservation
 Laboratory
 Radiology
 Dental Clinic # 3

Lloyd C. Hawks Troop Medical Clinic

Services 3rd Infantry Division and is two miles from Winn Army
 Community Hospital.

Services:

Primary Care
 Physical Exams
 Chiropractic Clinic
 Optometry

Radiology
 Laboratory
 Pharmacy
 Medical Records

Service Area Competitive Analysis

TriWest is the Managed Care Support Contract (MCSC) provider for Fort Riley, Kansas. TriWest works with local healthcare resources on behalf of Irwin Army Community Hospital to assist in expanding primary and specialty care resources available to eligible beneficiaries. Currently, there is a 59% overall provider participation within the Prime Service Area (PSA). The composition of the provider participation is as follows: 67 Primary Care Managers (7 in Manhattan and 13 in Junction City), 264 Specialists, 62 Behavioral Health, 17 Ancillary Services and 16 Institutions. The PSA is confined in a forty mile radius of Fort Riley known as a catchment area (see Figure 6). The most referenced reasons given to TriWest for not

participating in the TRICARE network is that practices are at full capacity and TRICARE reimbursement rates are inadequate. As shown in Table 3, a breakdown of network provider participation and local enrolled beneficiary populations within the PSA can be seen. This low participation coupled with the lack of services provided within the PSA, forces beneficiaries to travel greater distances to receive necessary care and wait longer periods of time to be seen. Table 4 shows the distances and average length of time to get network specialty care. Local network participation by Primary Care providers seems to increase the further and more rural they are away from the more densely populated areas in which our enrollees live. This comparison can be seen in Figure 7.

Manhattan Surgical Center

Manhattan Surgical Center is located in Manhattan, Kansas, and is licensed by the Kansas Department of Health and Environment. It treats over 4,900 patients annually and has 4 operating rooms, 2 endoscopy suites, 2 recovery areas and 7 inpatient rooms. Ninety percent of patients are discharged from the facility within 24 hours. Manhattan Surgical Center is locally owned, governed and managed. There are over 35 physicians and anesthesia providers who use the facility on a regular basis (Manhattan Surgical Center, 2007).

Services:**General Surgery**

Breast Biopsy
 Lymph Node Excision
 (Superficial)
 Herniorrhaphy, Inguinal or
 Umbilical
 Hemorrhoidectomy
 Mastectomy
 Gallbladder Removal
 Thyroid Removal
 Peripheral Vascular Surgery
 Exploratory Laparotomy

Ear, Nose and Throat

Tonsillectomy and
 Adenoidectomy
 Tympanostomies (Tubes in
 Ears)
 Closed Reduction Nasal
 Fracture
 Nasal Septal Reconstruction
 Rhinoplasty

Gastroenterology

E.G.D.
 Colonoscopy
 Balloon Dilation
 Liver Biopsy
 Feeding Tube Placement
 Flexible Sigmoidoscopy
 Paracentesis

Gynecology

D&C
 Laparoscopy (Diagnostic)
 Laparoscopic Tubal Ligation
 LEEP Procedure
 Vaginal Hysterectomy
 Abdominal Hysterectomy
 Bladder and Uterus Suspension

Oral Surgery

Teeth Extraction
 Periodontal Surgery

Orthopedic Surgery

Arthroscopy (Shoulder, Wrist,
 Hip, Knee and Ankle)
 Carpal Tunnel Release
 Tendon Repair
 Removal of Hardware
 ACL Reconstruction
 Discectomy (Lumbar)
 Partial Knee Replacement
 Total Hip Replacement
 Laminectomy (lumbar)
 Treatment of Extremity
 Fractures
 Foot and Ankle Surgery

Plastic Surgery

Blepharoplasty (Eyelid
 Wrinkles)
 Liposuction (Body Sculpting)
 Face LiFort
 Otoplasty
 Augmentation Mammoplasty
 Skin GraFort

Podiatry (Foot Surgery)**Urology**

Cystoscopy
 Urethral Dilation
 Vasectomy
 Biopsies
 Vasovasotomy
 Lithotripsy
 Prostate Surgery
 Bladder Surgery

Pain Management

Epidural Steroid Injections
 Peripheral Nerve Blocks

Mercy Regional Health Center

Mercy Regional Health Center is an acute care facility licensed to operate 150 beds in two facilities. This private, not-for-profit organization was created to reflect the combined healthcare strengths of St. Mary's and Memorial Hospital in 1996. Mercy is committed to meeting our community's healthcare needs through a quality, compassionate, modernized healthcare delivery system which includes more than 100 physicians and over 700 employees serving the people of Manhattan and the surrounding areas with a wide range of quality health and wellness services (Mercy Regional Health Center, 2008). Mercy is partners with the Riley County Emergency Medical System, Wamego City Hospital and Via Christi Health System. Via Christi is Kansas' largest health system and their focus ranges from Acute and Outpatient Care to Senior Care and even Insurance. By Mercy being a part of Via Christi Health System, there is a financial advantage that is created over that of community hospitals. This financial advantage stems from the ability of Via Christi to be able to re-appropriate capital from other parts of their health system to support the financial requirements within other areas without having to request funding from the community like in a community hospital. This enables Mercy to react to the needs of the community and the health system's strategic plan at a more expedited pace.

It is that quality of life that retains and attracts citizens to the beautiful Flint Hills. Quality of life is the perception of home. As with most people, continually improving and making home the very best quality and the most comfortable is exactly what Mercy Regional Health Center's expansion efforts are about (Mercy Regional Health Center, 2008).

Mission:

To promote community health by providing quality, compassionate health care services that embrace our values (Mercy Regional Health Center, 2008).

Vision:

Mercy Regional Health Center will be the provider of choice for health care services in the region by: Expanding our service capabilities, fulfilling our role as a community citizen, achieving a high level of integration with our physicians, outlying communities, and Via Christi. Our vision will be achieved in keeping with our core values of: Quality, Human Dignity, and Community (Mercy Regional Health Center, 2008).

Services:

Behavioral Health
Birth and Women's Center
Cardiopulmonary Services
Case Management
Critical Care Unit
Diabetes Center
Emergency Department
Fitness Center
Home Medical Services

Hospital Support
Joint Care Center
Nutrition Clinic
Occupational Health
Pain Management
Pediatrics
Pharmacy
Radiology
Rehabilitation

Sleep Disorder Services
Surgical Services

Support Groups
Weight Management

Geary Community Hospital

Geary Community Hospital is a 92-bed, not-for-profit hospital that offers outstanding care to patients while providing an enjoyable work environment for all employees. With a 105,000 square foot expansion underway, the hospital will soon house a new Intensive Care Unit, Medical/Surgical Unit, Surgical Center, and a newly remodeled Radiology Department. With a mission to provide accessible, professional, cost-effective primary and secondary healthcare to Geary County and surrounding communities, Geary Community Hospital uses state-of-the-art techniques to ensure each patient receives the care they deserve (Geary Community Hospital, 2008).

Mission:

To provide accessible, professional, cost-effective primary and secondary health care to Geary County and other communities (Geary Community Hospital, 2008).

Motto:

Progressive Healthcare. Hometown Compassion (Geary Community Hospital, 2008).

Vision:

To become a regional medical center by providing exceptional care and services to 100% of the market (Geary Community

Hospital, 2008).

Inpatient Services

Inpatient Rehabilitation
Intensive Care Unit
Medical/Surgical
Senior Health Center
Women's Health Center

Outpatient Services

Cardiopulmonary
Emergency Department
Home Health
Home Medical Equipment
Hospice
Surgical Weight Loss
Occupational Health Services
Outpatient Rehabilitation &
Fitness
Radiology

Surgical Services

Anesthesia
Operating and PACU
Surgery Center

Outpatient Clinics

Audiology Clinic

Internal Environment

Cardiology Clinic
Dermatology Clinic
Dialysis (Full-time kidney
dialysis)
Ear, Nose, and Throat (Both
surgery and clinic)
Konza Oral and Maxillofacial
Surgery (Both surgery and
clinic)
Konza Prairie Community
Health Center
Neurology Clinic
Oncology (Chemotherapy
treatments only)
Orthopaedic Surgery and
Sports Medicine (Both surgery
and clinic)
Ophthalmology (Both surgery
and clinic)
Pediatric Cardiology
Podiatry (Both surgery and
clinc)
Urology (Both surgery and
clinic)
Wound Care

Fort Riley was officially established in 1853 by War Department General Order No. 17, dated June 27, 1853, proclaiming Fort Riley as a permanent post. Fort Riley, as an Installation of Excellence, works in close partnership with local, regional and state communities to provide trained and ready forces to meet Joint Force requirements across the full spectrum of current and future operations; transforms and manages unit readiness as directed by the Army Campaign Plan;

executes unit re-stationing as directed by FORSCOM; executes garrison operations as directed by Installation Management Command, and conducts homeland defense operations and supports civil authorities (Fort Riley, 2007)

Fort Riley, Kansas medical support structure.

Irwin Army Community Hospital

Construction of the new 250 bed post hospital began on July 19, 1955, and was completed in 1958 at a cost of \$6 million. A later expansion of the hospital was completed in 1978 at a cost of \$21.108 million. Currently, 17 of the 23 outpatient clinics at IACH are housed in the outpatient wing (Irwin Army Community Hospital, 2007).

Scope of Services (FR MEDDAC Memorandum No. 40-132, 07 February 2007):

Allergy/Immunization Clinics	Service
Department of Nursing	Orthopedic services
Ambulatory Surgery Center	Otolaryngology - Head/Neck
Anesthesia and Operative Service	Service
Army Substance Abuse Program	Department of Pathology
Audiology	Department Laboratory Services
Brace Shop	CTMC Ancillary Support Services
Case Management/Discharge	Perioperative Services
Planning	Pharmacy
Consolidated Troop Medical	Physical Therapy Clinic
Clinic	Podiatry Clinic
Dermatology	Post-Anesthesia Care Unit
Emergency Medicine Service	Preventive Medicine Service
General Surgery Service	Primary Care Teams #1, 2, and 3
Department of Ministry &	Department of Radiology
Pastoral Care	Respiratory Therapy
Nutrition Care	Social Work Services
Obstetrics & Gynecology Service	Special Care Unit (SCU)
Occupational Therapy	Ward 2B
Ophthalmology	Well Baby Clinic
Optometry Clinic	
Oral and Maxillofacial Surgery	

A comparative chart of the relevant services provided by Irwin Army Community Hospital and those of other healthcare facilities within the catchment area can be seen in Table 5. The majority of the common services provided by all are primary care services, general surgical services and the associated clinical services needed to conduct them. Since Manhattan Surgical provides specific and limited surgical services, it will no longer be discussed in this comparison. The remaining two facilities, Geary Community Hospital and Mercy Regional Hospital, have a propensity to offer services that Irwin Army Community Hospital does not. These services include, but are not limited to: Cardiopulmonary, Surgical Weight Loss, Sleep Disorder Services, Intensive Care Services, Neurology and Urology. A hasty analysis of this chart could lead one to believe that between all three facilities there would be enough services provided to take care of any beneficiary's medical need. This assumption does not take into account that local civilian facilities were built to provide for their respective populations and not that of the rapidly increasing number of active duty personnel and their respective families on Fort Riley. This continually increasing population of Fort Riley has not only exceeded the capacity of services provided by Irwin Army Community Hospital but that of the local network as well. This creation of a saturated healthcare market has required all

facilities to address and expand their physical structures and services provided.

Existing Strategies

Directional Strategies

Services

Services currently provided can be seen in Table 5. Though currently over-enrolled by approximately 6000 beneficiaries, efficiency in provider productivity assists in meeting demand. Irwin Army Community Hospital services have been and currently remain affected by the deployment of providers and key personnel in support of the Global War on Terrorism. On average, 30 IACH staff members are deployed during the year. Back fill of our deployed members is conducted by the Reserve component at a replacement standard of 50%. Due to Reservist deployments, the hospital average has only been a 13% backfill rate. The services most affected by deployment are: Nursing, Dermatology, Primary Care, Surgery and the Emergency Department. Initiatives such as Tele-Derm, hiring a part-time Allergist and the hiring of a contract provider have been undertaken to help offset these losses, but limited availability due to the rural geographic location has hindered overall effectiveness.

Facility

Irwin Army Community Hospital has been under constant renovations and expansion projects since 2006 and will continue

through 2013. These projects will help bridge the facilities gap until a projected approval of funds for a new facility by 2013. In 2006, the preparation for hospital renovations was initiated by the procurement of seven modular buildings for administrative services within the main facility to occupy. This in turn, allowed clinical services to be relocated in the formerly occupied administrative areas during clinic renovations. The first of the clinics to be renovated were the primary care clinics in 2006. This was done systematically to allow primary care services to continue their operations while minimizing the inconvenience to the beneficiary.

In 2007, funding was recommended for multiple new projects. A 54,899 square foot Soldier & Family Care Clinic was approved to accommodate an additional 21,517 enrollees. The projected start date for this new facility is 2009. Several other renovation projects were approved in 2007 and include: final phase of roof repair, second floor renewal (OR, Med-Surg, SCU and ACU) Outpatient pharmacy in new AAFES shopping center and an additional parking lot. Between 2008 and 2013, continual improvements to the existing facility will occur in order to maintain up to date compliance of standards and expand the existing structure to support current and new services. The estimated total for all projects, to include a new hospital, is projected to be \$553 million. Facility data was gathered from a

November 2007 *Space Utilization Plan* brief given by Jon Cranmer, IACH's Facility Manager, and a February 2008 *IACH Recapitalization Plan* brief given by the US Army Health Facility Planning Agency to Brigadier General Gilman, GPRMC Commander.

Referral Recapturing

To come up with a true picture of Irwin Army Community Hospital's purchased care (PC) costs for the current population, data was pulled in FY 07 using the M2 data system, for patients enrolled to IACH or subordinate clinics (enrollment parent DMIS 0057). This data created a starting point to identify potential costs that could be captured through expansion of or initiation of services provided by IACH.

When looking at purchased care data, some reporting systems such as the Command Management System (CMS), commonly look at catchment area care only. Given the population's medically underserved area and IACH's reliance on major medical centers outside of the catchment area for specialty care, data was pulled for inputs that used the 60000 series provider zip codes. These zip codes include the catchment area as well as care in Kansas City, Topeka, Salina and Wichita and other metropolitan areas. Data for this assessment can be reviewed in Tables 6 and 7.

Inpatient data was pulled by Major Diagnostic Category(ies) (MDC). M2 does not allow data to be pulled by provider

specialty code for inpatient care. MDC includes major diagnostic groupings and includes all billed care associated with the MDC. For example, MDC 6, Diseases of the Digestive System, includes internal medicine, gastroenterology or surgical costs as well as other associated costs such as anesthesia, radiology, lab and facility charges. Many times these associated costs are overlooked when data is pulled by a specific provider for cost recapture purposes. Inpatient purchased care costs, for the data collection period of FY07 are \$7.22 million. Referred inpatient services with highest cost to Irwin Army Community Hospital have been historically consistent. These services are: Mental Health, Respiratory, Pregnancy and Child, and Musculoskeletal.

Outpatient data was pulled by MDC as well as provider specialty code. Outpatient care by MDC will allow the user to see the provider specialty codes bundled into an MDC. For example, general practice, provider specialty code 1, has charges against virtually all MDC codes. There are also anesthesia and facility charges against most MDCs. This data also points out the need to look at all outpatient purchased care charges, when looking at recapture, instead of only looking at a specific provider specialty code. For example, outpatient MDC 11, Kidney and Urinary Tract, includes charges for urology, lab, radiology, anesthesia, and facility charges. All of these

should be considered if one is considering recapturing urology workload. Outpatient costs for the data collection period of FY07 are \$17.3 million. Referred outpatient services also demonstrate historical consistency. The highest referred outpatient services are: Primary Care, Emergency Room, Mental Health, Orthopedics and Optometry.

Potential Strategies

Threats Opportunities Weaknesses Strengths (TOWS)

The threats that currently face Irwin Army Community Hospital are those from a continually increasing population that cannot be adequately supported within. These threats are caused by several variables and the first being that of IACH's current support structure. As stated before, the ASAM is built two years prior to implementation, thus creating an improper balance in provider to population ratios due to frequent changes to Fort Riley's population due to the Department of the Army directives. Another threat is the utilization rate of services provided to members of the Warriors in Transition Unit. This not previously forecasted and unpredictable population size is in addition to the previously established forecasted numbers and combined with their increased utilization rate and enhanced access to care standards, creates a higher demand than available capacity. This overall increase in demand by enrollees causes an increased

need to send workload to the local network. Another not previously forecasted population is those Soldiers assigned here on a temporary basis for training, mobilization and demobilization in support of Military Transition Teams (MiTT). This population fluctuates from 500 to over 1200 Soldiers at any given time during the year and must be treated from within the limited capacity that is at IACH. The local healthcare support is the remaining threat to Irwin Army Community Hospital. With an already limited support structure surrounding Fort Riley, many of the participating network services have reached capacity. The threat of network saturation forces military beneficiaries to travel greater distances, sometimes up to two hours, to receive treatment.

Irwin Army Community Hospital has a myriad of opportunities it can pursue. The majority of them hinge on the expansion of current services provided and the introduction of new services. Service expansion and introduction encompass both inpatient and outpatient areas. Additional opportunities position themselves with partnerships with local facilities and the cooperation of the MCSC to increase the reimbursement rates for services.

A weakness faced by IACH is the length of time to affect change due to it being a federal facility. This not only affects the support structure of the hospital, but the funding for projects as well. Dependant upon the cost of the endeavor,

approval for funding can sometimes require Congressional approval. The total time for implementation of initiatives is also a function of the level at which it must be approved and directly affects the population support.

The strengths of Irwin Army Community Hospital are unique to the work of the staff. The staff of IACH are very adaptive and supportive. These characteristics create a proactive and productive healthcare environment. IACH proactively looks ahead and assesses the future environment to initiate timely modifications of implementations to the MTF. This is achieved through the participation and input of all departments of the hospital so that the pitfall of planning in a vacuum does not occur. This proactive nature has enhanced the productivity levels as well. Constant monitoring of provider productivity has increased the quantity of services that are available to our enrollees. This has not only increased appointments available but also productivity reimbursement to the facility through the Performance Based Assessment Model (PBAM).

Adaptive Strategies

To meet the demand created by the current and future population, and to account for the lack of services provided or limited participation within the local network, the expansion of services provided by Irwin Army Community Hospital is vital. Not only will the expansion assist in servicing the population but it will also assist in recapturing purchased care expenditures for outpatient and inpatient services. There are intangible benefits directly related to the increasing of services to the community. By ensuring that there is an increased amount of access to various services, customer satisfaction will increase and an improved quality of care perception will also result.

The largest internal outpatient service that needs to be addressed is that of primary care. Primary Care consists of Family Practice, Internal Medicine and Pediatric providers. Primary Care providers are the gatekeepers to specialty providers and their services within the hospital. Through a patient's initial assessment, subsequent causes for illness can be identified for continued investigation and treatment. As shown in Figure 4, the FY 06 supported population dictated a need for approximately 25 Primary Care providers. With the impending forecasted population of approximately 56K in FY 13, seen in Figure 5, an increase of Primary Care providers to at

least 46 is required. This increased gap of 21 providers can be obtained through several ways. Historically, filling of these positions with military providers has not been the best option due to the chronic under strength of military providers in MEDCOM and line units across the Army. This requires filling these positions through Government Service (GS) or contract hiring. The majority of GS hiring is done locally, but in some circumstances achieved by the relocation of providers from other geographic locations. Additional GS hiring can be accomplished after a contract provider locates to the facility and then elects employment as a GS employee. At IACH, contract hiring is generally worked through TriWest. Filling of contract providers is also hindered by the rural location of the MTF. The network provider support created by TriWest is a viable option to pursue. As seen in Figure 7, the majority of the network Primary Care providers are not located within a 20 minute drive from Fort Riley. This lends itself to ask the question, "Why are providers located further away from Fort Riley so willing to be in the network pool?" The answer could simply be that they do not have sufficient workload and are willing to be network providers in order to increase their empanelment. If this holds true, contacting these providers and negotiating for part-time services at Irwin Army Community Hospital is a viable option. In order to meet the impending population of the upcoming years,

continual forecasting and requests to over-hire more than what is currently authorized will be the only means to set up the proper structure for the next years.

Next is the enhancement of Irwin Army Community Hospital's outpatient and establishment of inpatient mental health services. Current purchased care for outpatient mental health services is almost \$900K. This is attributed to the limited services available to active duty members, a rise in mental health demand due to the Global War on Terrorism and the lack of services available to family members. The need to establish a robust behavioral health center is required in order to meet the high demand and to recapture purchased care costs. Through assessment of the facility renovation and building improvement plans, the best timeframe to establish such a clinic is upon completion and occupation of services in the administrative building.

Also, contingent upon the renovations of IACH is the development of inpatient mental health services. In FY 07, over \$1 million was spent receiving this care from other facilities. The original design of Irwin Army Community Hospital established an inpatient mental health ward, but it is no longer in service. Current driving distances to receive these services add to the need to develop the service in house. Inpatient Mental Health facilities utilized by IACH (Map and Distance) can be seen in

Figure 8. An additional need to develop an inpatient mental health service is largely supported by the reimbursement rates offered to supporting facilities. Not all inpatient cases are completed in the Length of Stay (LOS) times prescribed by their presented conditions. The lower reimbursement rates could cause supportive facilities to retract their care and ultimately provide support for the creation of an MTF inpatient service. The overall timeline to establish this service is dependant on development and approval of a business case analysis of an inpatient mental health ward along with needed renovations of the facility. If this service does not see fruition in the current facility, the requirement of need will be established and taken under advisement in the design of the future hospital.

Additional inpatient services that can be expanded are the services provided for Pregnancy and Childbirth and surgical services. The purchased care that can be recaptured through the expansion of Pregnancy and Childbirth services for both inpatient and outpatient services is in excess of \$1.4 million. This can be done through increasing the available Labor, Delivery, Recovery, Post-Partum (LDRP) birthing suites beyond current availability. With an increase of LDRPs, the necessary staff required to meet demand is also required. This staffing increase can be done through projecting staffing requirements for over hire requests.

The scope of services provided by current surgical providers is another adaptive strategy that can meet the demand of purchased care services provided. Some prospective services that can be established are noninvasive weight loss surgery and increased scope of orthopedic surgeries. Noninvasive weight loss surgery, i.e. Lap-Band, is a TRIACARE reimbursable procedure. This service can be done for Soldiers that have exhausted all other avenues to obtain weight loss, but also by family members. With the establishment and proficient execution of a Lap-Band program, this service can be extended to other MTF's within the region. By expanding the services provided by IACH's orthopedic surgeons, the recapture of care and an expansion in demographics that are able to be treated will be enhanced. This increase in scope of surgical procedures can be accomplished through a business case analysis that is completed and approved in synchronization with the completion of renovations of the operating room suites.

Making Irwin Army Community Hospital a "Center of Excellence" is another way to increase production. The previously mentioned Lap-Banding venture is one way to accomplish this. Another means to obtain this is that of corrective eye surgery. IACH is the only GPRMC hospital of its size to have a LASIK eye-laser. Prior to procurement of the eye-laser, Soldiers were sent to other MTFs to have this

procedure done. Since Fort Riley is centrally located, the capture of these procedures from other regional facilities can be accomplished.

The last adaptive strategy for Irwin Army Community Hospital is through establishment of external sharing agreements. There is a need to expand the number of local providers accepting TRICARE payment for specialty care. Some of the services include but are not limited to: orthopedic surgery, cardiology and neurology. Irwin Army Community Hospital does not offer cardiology and neurology services, and requires patients to travel up to an hour to receive these services. The limited services for orthopedics also forces beneficiaries to travel over an hour for treatment. Through active communications between the local providers and TriWest, an increased local level of access can be achieved at reduced travel distances and times for the beneficiary.

Strategy Map

The mapping of the potential strategies is broken down by course of action and facility requirements in their respective fiscal years. These actions and facility requirements are a direct result of the significant events and its effect on the population of enrollees to IACH. Irwin Army Community Hospital's Potential Strategies Map can be seen in Appendix D. Respective business case analysis' and facility renovations or

construction are the keystone to implementing any of the potential strategies for the hospital. These services bridge the gap between the current situation and that of a new hospital.

The MEDCOM strategy map supports the mission and vision of the Army Surgeon General. The "means" are the fundamental tasks of the strategy map is how the "ways" (the defined tasks by related category) of the AMEDD, supporting an "Army at War", can be accomplished. The three means are: resources, learning and growth. The ways of the MEDCOM strategy map are broken into four areas: sustain, prepare, reset and transform. Each of these areas has internal processes to achieve the respective way. The complete MEDCOM strategy map can be seen in Appendix E. The Irwin Army Community Hospital strategy map is constructed in support of the MEDCOM strategy map. The components of IACH's strategy map, seen in Appendix F, reflect the same components as MEDCOM's but are facility specific in order to meet the mission established by higher.

Balanced Scorecard

The components of Irwin Army Community Hospital's balanced scorecard are derived from IACH's strategy map. Each component of the strategy map has objectives that must be monitored for compliance in order to succeed. The balanced scorecard defines these objectives through command approved objective statements

and is then given measures to assist in monitoring status. Each measure has a target level that when met, shows fulfillment of the intended metric. The constant monitoring and correction of deficient targets are assigned to a staff proponent that has correlation to the measure and target. This is monitored by the command of Irwin Army Community Hospital through a weekly status brief on a rotational schedule of responsible hospital sections.

Action Plan

The action plan for all new services planned for Irwin Army Community Hospital will be in accordance with the AMEDD's Business Case Analysis (BCA) guidance and tool. The BCA is a structured and systematic methodology for analyzing the alternatives involved in a business decision (AMEDD, 2008). This is a requirement to start any new services within the facility in addition to gaining authorization to receive new providers not previously filled in prior year TDA's. The Irwin Army Community Hospital's Clinical Operations Division will work with the Great Plains Regional Medical Command to provide the necessary supportive data and documentation to support the service strategies for the hospital. Business Case Analysis will be completed in enough time to ensure the initiation of the service coincides with completion of renovated or newly constructed facilities. The monitoring of these BCA supported strategies will be the responsibility of the Chief and Deputy

Chief of the Clinical Operations Division and the progress will be consistently reported to the leadership of IACH. At the time of submission for this paper, several strategies have been initiated and are in various stages of the planning process.

References

- Andrews, K.R. (1998). *The Concept of Corporate Strategy*. The Strategy Process: revised European edition. Europe. Prentice Hall.
- AMEDD Business Case Analysis (BCA) website (2008). Available at <https://ke2.army.mil/synergy/main.php?cid=142#>
- AMEDD Center & School. (1994). *The Benchmarking Methodology: Determining medical manpower needs* (Video Cassette Recording No. A1701-94-000072). Fort Sam Houston, TX. Health Sciences Media Division.
- AMEDD Center & School. (1998). *Automated Staffing Assessment Model (ASAM)* (Video Cassette Recording No. A1701-98-000070). Fort Sam Houston, TX. Health Sciences Media Division.
- Army Medical Department website (2007). Available at www.armymedicine.army.mil/
- ASAM brief presented to BG(P) Dennis Hardy. (2002, October). *United States Army Medical Command's Automated Staffing Assessment Model (ASAM)*. Fort Sam Houston, TX. MEDCOM.
- Barney, Jay B. (2005, July 14) *The Field of Strategic Management and Resource-based Theory*. Fisher College of Business-The Ohio State University

Blackerby, Phillip. (1994). *History of strategic planning.*

Armed Forces Comptroller. Vol. 39, no. 1. pp 23-24.

Crook, Kenneth. (1990). *The Development and Analysis of a Strategic Planning Process at Blanchfield Army Community Hospital, Fort Campbell, Kentucky.* U.S. Army Academy of Health Sciences. Fort Sam Houston, TX.

Cooper, Richard A. MD. (2000). Adjusted Needs? Modeling the Specialty Physician Workforce. *American Association of Neurological Surgeons.* Vol. 9, No 1 pages 13-14.

Cooper, Richard A, Getzen, Thomas E., McKee, Heather J., and Laud Prakash. (2002). Economic and Demographic Trends Signal an Impending Physician Shortage. *Health Affairs.* Vol. 21, No. 1. pp 140-154.

Cranmer, Jon. (2007). *Space Utilization Plan Brief.* Fort Riley, KS.

Dye, Renee. (2006). Improving strategic planning: A McKinsey Survey. McKinsey & Company. Atlanta, GA.

Fort Riley website (2007). Available at www.riley.army.mil

Fort Stewart website (2007). Available at www.stewart.army.mil/

FR MEDDAC Memorandum No. 40-132. (2007, February 7)

Geary Community Hospital website (2007). Available at www.gchks.org

Goldsmith, Arthur A. (1995). *Making managers more effective: Applications of strategic management.* U.S. Agency for

- International Development. Washington D.C.
- Grant, Robert M. (2005). *Contemporary Strategy Analysis*.
Cambridge, Massachusetts. Blackwell Publishers.
- Gray, Daniel H. (1986). *Uses and misuses of strategic planning*. Harvard Business Review. 64(1), pp 89-97.
- Halpern, Ralph and Boulter, Philip MD. (2000). Population-Based Health Care: Definitions and Applications. *Tufts Managed Care Institute*. Retrieved 9 January, 2008 from http://www.tmci.org/downloads/topic11_00.PDF.
- Haugstad, Bjorn. (1999). Strategic theory- a short review of the literature. The SINTEF Strategic Institute Program. Retrieved 4 April , 2007 from http://www.kunne.no/upload/Gamle%20publikasjoner/Nedtegnelser/Strategy%20Theory_N0299_Haugstad.pdf
- Hax, A.C. and Majluf, N.S. (1996). *The strategy concept and process: A pragmatic approach*. New Jersey. Prentice Hall.
- Irwin Army Community Hospital website (2007). Available at <http://iach.amedd.army.mil/>
- Jewett, Ethan. (2005). AAP Division of Graduate Medical Education & Pediatric Workforce. *American Academy of Pediatrics*.
- Kropf, Roger & Greenberg, James A. (1984). *Strategic analysis for hospital management*. Rockville, Maryland. Aspen

Publications.

Manhattan Surgical Center website (2007). Available at
www.manhattansurgical.com/

Manderscheid, RW and Henderson, MJ. (1995). Speaking with a
 common language : the past, present and future of data
 standards for managed behavioral healthcare. *Center for
 Mental Health Services*. Rockville, Maryland.

Mele, Domenec and Guillen, Manual. (October, 2006). The
 intellectual evolution of strategic management and its
 relationship with ethics and social responsibility. *IESE
 Business School-University of Navarra*.

Mercy Regional Health Center website (2007). Available at
www.mercyregional.org/

Quinn, J.B. (1998). *Strategies process: revised European
 edition*. Europe. Prentice Hall. Pegels, Carl C. & Rogers,
 Kenneth A. (1988). *Strategic management of hospitals and
 health care facilities*. Rockville, Maryland. Aspen
 Publications.

Robert M. Grant, *Contemporary Strategy Analysis*, 5th and 2nd
 eds., Blackwell Publishers, Inc., Cambridge,
 Massachusetts, 2005 and 1995.

Schendel, Dan E. & Hofer, Charlse W. (1979). *Strategic
 Management: A new view of business policy and planning*.
 Boston. Little, Brown and Company.

Snyder, Ralph, Sheldon, George F. and Bischoff, Theresa A.

(2002). Gauging Supply and Demand: The Challenging Quest to predict the future physician workforce. *Health Affairs*. Vol. 21, No. 1. pp 167-168.

Swayne, L.E., Duncan, W. J., and Ginter, P. M. (2006). *Strategic Management of Health Care Organizations*. Malden, MA: Blackwell Publishing.

TRICARE website (2007). Available at www.tricare.mil/

US Army Health Facility Planning Agency. (2008). *Irwin Army Community Hospital Recapitalization Plan IPR to BG Gilman*. Fort Sam Houston, TX.

US Department of Health and Human Services. (1990). *Healthy people 2000: national health promotion and disease prevention objectives*. *Public Health Service*. Washington DC.

Winkenwerder, William. (2007, February 13). The military health system overview statement by the Honorable William Winkenwerder, JR, MD, MBA, Assistant Secretary of Defense for Health Affairs before the subcommittee on military personnel armed services committee.

Winn Army Community Hospital website (2007). Available at www.winn.amedd.army.mil

Table 1.

Abridged History of Strategic Management

Period	1960's	1970's	1980's	1990's	2000
Label	Definition of Strategy	Conceptualizing Strategic Management	Industrial Organization Economics View of Strategy	Resource-Based View of Strategy	New paradigm for Strategic Management
Some leading authors	Chandler (1962) Ansoff (1965) Learned et al. (1965) Andrews (1971)	Rumelt (1974) Mintzberg (1978) Ansoff (1979)	Porter (1980) Porter (1986)	Bartlett (1979) and Ghoshal (1986) Wernerfelt (1984) Barney (1991) Prahalad and Hamel (1990)	Nonaka (1991) Hamel (2000) Pfeffer and Sutton (2000)
Dominant themes	Corporate strategy, planning and growth	Strategic management content and process	Competitive advantage development	Resources and capabilities development	Learning, Knowledge and Innovation
Rationale	Strategy as a rule for making decisions	Evaluation and implementation of critical aspects of formulated strategy	Five forces analysis of the industry attractiveness to develop competitive advantage through generic strategies	Valuable, rare and costly to imitate resources without close substitutes can be sources of sustained competitive advantage	Dynamic strategic model by which firms obtain valuable information, create knowledge and accumulate intangible capabilities in a process of learning
Strategic concepts, tools & techniques	SWOT; Experience Curve; Growth Share Matrix	Value Chain	5 forces model Strategic choice	Core Competence Value System; VRIO; Game Theory	New integrated Information Technology Systems

Adapted from: Mele, Domenec and Guillen, Manual. (October, 2006). The intellectual evolution of strategic management and its relationship with ethics and social responsibility. *IESE Business School-University of Navarra*.

Table 2.

The Evolution of Strategic Management/Strategic Planning

Period	1950's	1960's and Early 1970's	Late 1970's and early 1980's	Late 1980's and early 1990's	2000+
Dominant Theme	Budgetary planning & control.	Corporate planning.	Strategic Positioning. Analysis of industry & competition.	Strategic competitive advantage.	Strategic and organizational innovation.
Main Focus and Issues	Financial control, especially through operating budgets.	Planning growth, especially diversification and Portfolio Planning.	Selecting industries and markets. Positioning for market leadership.	Focusing strategy around Sources of competitive advantage. Dynamic aspects of strategy.	Reconciling size with flexibility & responsiveness.
Principal Concepts & Techniques	Financial budgeting. Investment planning. Project appraisal.	Medium- and long-term forecasting. Corporate planning techniques. Synergy.	Industry Analysis. Competitor analysis. Segmentation. Experience curves. PIMS analysis. SBU's (Strategic Business Units). Portfolio Planning.	Resources and capabilities. Shareholder value. Knowledge management. Information Technology. Analysis of speed, responsiveness & first-mover advantage.	Cooperative strategies. Competing for standards. Complexity & self-organization. Corporate social responsibility. Renewed commitment to ethics.
Organizational Implications	Systems of operational and capital budgeting become key mechanisms of coordination and control.	Creation of corporate planning departments & long-term planning processes. Mergers & acquisitions.	Multidivisional & multinational structures. Greater industry & market selectivity. Divestment of unattractive business units.	Restructuring. Continuous improvement & process reengineering. Refocusing. Outsourcing. E-business.	Alliances and networks. New models of leadership. Informal Less reliance on direction, more on emergence.

Adapted from: Robert M. Grant, Contemporary Strategy Analysis, 5th and 2nd eds., Blackwell Publishers, Inc., Cambridge, Massachusetts, 2005 and 1995.

Table 3.
PSA Network Provider Participation in
TRICARE

Service	Number In The PSA	Number Participating	Percent of Participation
Dermatology	3	2	67%
Emergency Room	16	13	81%
Family Practice	100	65	65%
Internal Medicine	22	16	73%
Mental Health	40	20	50%
Neurology	3	3	100%
Orthopedics	9	0	0%
Pediatrics	9	2	22%
Radiology	13	2	15%

Table 4.
Distance and Length of Time to Receive Network Specialty Care

Specialty	Closest Network Provider	Distance	Driving Time	Time to Get Appt
Allergy	Topeka/JC	62 miles	65 minutes	1-3 weeks
Audiology	Manhattan	14 miles	27 minutes	2 weeks
Cardiology	Salina	56 miles	62 minutes	4 weeks
Cardio, Pediatric	Kansas City	129 miles	125 minutes	4 weeks
Dermatology	Manhattan	14 miles	27 minutes	1 week
Endocrinology	Salina	56 miles	62 minutes	4 weeks
Gastroenterology	Manhattan	14 miles	27 minutes	4 weeks
Genetics	Kansas City	129 miles	125 minutes	6 weeks
Mental Health	Junction City	6 miles	16 minutes	4 weeks
Nephrology	Topeka	62 miles	65 minutes	4-6 weeks
Neurology	Manhattan	14 miles	27 minutes	4 weeks
Neurosurgery	Salina	56 mile	62 minutes	2-3 weeks
Oncology	Junction City	6 miles	16 minutes	1 week
Orthopedics	Topeka	62 miles	65 minutes	1-2 weeks
Pain Clinic	Manhattan	14 miles	27 minutes	2 weeks
Plastic Surgery	Topeka	62 miles	65 minutes	2-4 weeks
Pulmonology	Manhattan	14 miles	27 minutes	1-2 weeks
Rheumatology	Topeka	62 miles	65 minutes	2-4 weeks
Urology	Manhattan	14 miles	27 minutes	1 week

Table 5.

IACH Inpatient Purchased Care Cost for FY 07

Purchased Care Inpatient Care		FY			
Diagnosis Group	Data	2005	2006	2007	Grand Total
01 = Infection & Parasites (codes 001-139)	Sum of Number of Births, Raw	0	0	0	0
	Sum of Admission Count, Raw	9	21	19	49
	Sum of Amount Paid, Raw	\$ 39,409.01	\$ 95,008.50	\$ 229,293.01	\$ 363,710.52
02 = Neoplasms (codes 140-239)	Sum of Number of Births, Raw	0	0	0	0
	Sum of Admission Count, Raw	35	43	49	127
	Sum of Amount Paid, Raw	\$ 279,163.68	\$ 424,083.91	\$ 481,573.39	\$ 1,184,820.98
03 = Endocrine & Metabolism (codes 240-279)	Sum of Number of Births, Raw	0	0	0	0
	Sum of Admission Count, Raw	85	60	63	208
	Sum of Amount Paid, Raw	\$ 464,809.56	\$ 406,738.27	\$ 412,111.03	\$ 1,283,658.86
04 = Blood (codes 280-289)	Sum of Number of Births, Raw	0	0	0	0
	Sum of Admission Count, Raw	7	15	10	32
	Sum of Amount Paid, Raw	\$ 26,828.83	\$ 102,743.69	\$ 32,552.88	\$ 162,125.40
05 = Mental (codes 290-319)	Sum of Number of Births, Raw	0	0	0	0
	Sum of Admission Count, Raw	214	159	237	610
	Sum of Amount Paid, Raw	\$ 761,951.83	\$ 517,342.12	\$ 894,581.77	\$ 2,173,875.72
06 = Nerves & Senses (codes 320-389)	Sum of Number of Births, Raw	0	0	0	0
	Sum of Admission Count, Raw	27	15	22	64
	Sum of Amount Paid, Raw	\$ 120,467.07	\$ 624,394.21	\$ 213,197.44	\$ 958,058.72
07 = Circulatory System (codes 390-459)	Sum of Number of Births, Raw	0	0	0	0
	Sum of Admission Count, Raw	62	82	57	201
	Sum of Amount Paid, Raw	\$ 820,465.48	\$ 809,040.75	\$ 484,155.96	\$ 2,113,662.19
08 = Respiratory System (codes 460-519)	Sum of Number of Births, Raw	0	0	0	0
	Sum of Admission Count, Raw	43	58	60	161
	Sum of Amount Paid, Raw	\$ 357,662.83	\$ 456,822.71	\$ 584,163.05	\$ 1,398,648.59
09 = Digestive System (codes 520-579)	Sum of Number of Births, Raw	0	0	0	0
	Sum of Admission Count, Raw	56	88	60	204
	Sum of Amount Paid, Raw	\$ 294,699.14	\$ 339,636.89	\$ 367,043.31	\$ 1,001,379.34
10 = Genitourinary (codes 580-629)	Sum of Number of Births, Raw	0	0	0	0
	Sum of Admission Count, Raw	62	65	77	204
	Sum of Amount Paid, Raw	\$ 167,156.42	\$ 238,617.54	\$ 294,919.01	\$ 700,692.97
11 = Pregnancy and Childbirth (codes 630-677)	Sum of Number of Births, Raw	95	115	173	383
	Sum of Admission Count, Raw	106	147	196	449
	Sum of Amount Paid, Raw	\$ 239,171.63	\$ 346,123.03	\$ 468,711.31	\$ 1,054,005.97
12 = Skin (codes 678-709)	Sum of Number of Births, Raw	0	0	0	0
	Sum of Admission Count, Raw	10	9	15	34
	Sum of Amount Paid, Raw	\$ 30,578.15	\$ 39,252.56	\$ 38,543.70	\$ 108,374.41
13 = Musculoskeletal (codes 710-739)	Sum of Number of Births, Raw	0	0	0	0
	Sum of Admission Count, Raw	58	50	51	159
	Sum of Amount Paid, Raw	\$ 405,705.99	\$ 383,458.36	\$ 519,502.73	\$ 1,308,667.08
14 = Congenital Anomalies (codes 740-759)	Sum of Number of Births, Raw	0	0	0	0
	Sum of Admission Count, Raw	12	12	12	36
	Sum of Amount Paid, Raw	\$ 738,686.80	\$ 702,094.27	\$ 211,981.91	\$ 1,652,762.98
15 = Prenatal (codes 760-779)	Sum of Number of Births, Raw	0	0	0	0
	Sum of Admission Count, Raw	15	5	3	23
	Sum of Amount Paid, Raw	\$ 787,819.37	\$ 19,184.93	\$ 11,003.98	\$ 818,008.28
16 = Ill-defined (codes 780-799)	Sum of Number of Births, Raw	0	0	0	0
	Sum of Admission Count, Raw	36	46	57	139
	Sum of Amount Paid, Raw	\$ 102,017.52	\$ 140,431.87	\$ 179,313.57	\$ 421,762.96
17 = Injury & Poisoning (codes 800-999)	Sum of Number of Births, Raw	0	0	0	0
	Sum of Admission Count, Raw	94	88	62	244
	Sum of Amount Paid, Raw	\$ 649,830.26	\$ 877,307.30	\$ 800,863.56	\$ 2,128,001.12
18 = Supplementary Classifications (Codes V**)	Sum of Number of Births, Raw	0	0	0	0
	Sum of Admission Count, Raw	38	85	103	226
	Sum of Amount Paid, Raw	\$ 576,369.92	\$ 1,135,316.56	\$ 1,198,526.14	\$ 2,910,212.62
Total Sum of Number of Births, Raw		95	115	173	383
Total Sum of Admission Count, Raw		969	1048	1153	3170
Total Sum of Amount Paid, Raw		\$ 6,862,793.49	\$ 7,657,597.47	\$ 7,222,037.75	\$ 21,742,428.71

Table 6.

IACH Outpatient Purchased Care Cost FY07

Purchased Outpatient Care by Diagnosis Group Code		FY			
DG Description	Data	2005	2006	2007	Grand Total
01 = Infection & Parasites (codes 001-139)	Sum of Number of Visits, Raw	792	866	1305	2963
	Sum of Number of Services, Raw	4887	2644	6455	13986
	Sum of Amount Paid, Raw	\$ 115,089.00	\$ 112,950.37	\$ 207,803.43	\$ 435,842.80
02 = Neoplasms (codes 140-239)	Sum of Number of Visits, Raw	1253	1901	2119	5273
	Sum of Number of Services, Raw	18077	54008	44172	116257
	Sum of Amount Paid, Raw	\$ 665,255.07	\$ 1,180,505.42	\$ 1,150,678.89	\$ 2,996,439.38
03 = Endocrine & Metabolism (codes 240-279)	Sum of Number of Visits, Raw	1161	1218	1407	3786
	Sum of Number of Services, Raw	8864	13882	10666	33412
	Sum of Amount Paid, Raw	\$ 393,538.77	\$ 347,897.89	\$ 457,321.51	\$ 1,198,758.17
04 = Blood (codes 280-289)	Sum of Number of Visits, Raw	239	218	296	753
	Sum of Number of Services, Raw	1207	2451	5933	9591
	Sum of Amount Paid, Raw	\$ 71,624.03	\$ 85,026.23	\$ 142,163.08	\$ 298,813.34
05 = Mental (codes 290-319)	Sum of Number of Visits, Raw	16126	16489	16646	49261
	Sum of Number of Services, Raw	18027	20125	20084	58236
	Sum of Amount Paid, Raw	\$ 1,036,646.44	\$ 1,075,150.50	\$ 1,050,007.99	\$ 3,161,804.93
06 = Nerves & Senses (codes 320-389)	Sum of Number of Visits, Raw	10539	8973	8890	28402
	Sum of Number of Services, Raw	28567	31586	21329	81482
	Sum of Amount Paid, Raw	\$ 904,677.38	\$ 934,129.28	\$ 1,101,228.45	\$ 2,940,035.11
07 = Circulatory System (codes 390-459)	Sum of Number of Visits, Raw	2502	3129	2964	8595
	Sum of Number of Services, Raw	10783	17929	13512	42224
	Sum of Amount Paid, Raw	\$ 628,106.27	\$ 944,390.42	\$ 705,587.95	\$ 2,278,084.64
08 = Respiratory System (codes 460-519)	Sum of Number of Visits, Raw	4347	4367	5158	13872
	Sum of Number of Services, Raw	22110	25379	23121	70610
	Sum of Amount Paid, Raw	\$ 548,534.99	\$ 581,682.36	\$ 703,438.09	\$ 1,833,655.44
09 = Digestive System (codes 520-579)	Sum of Number of Visits, Raw	1698	1808	1887	5393
	Sum of Number of Services, Raw	10219	13331	9685	33235
	Sum of Amount Paid, Raw	\$ 519,484.21	\$ 668,316.93	\$ 636,277.09	\$ 1,824,078.23
10 = Genitourinary (codes 580-629)	Sum of Number of Visits, Raw	3025	3729	3652	10406
	Sum of Number of Services, Raw	24648	37096	30541	92285
	Sum of Amount Paid, Raw	\$ 964,058.67	\$ 1,132,733.63	\$ 1,040,678.60	\$ 3,137,470.90
11 = Pregnancy and Childbirth (codes 630-677)	Sum of Number of Visits, Raw	829	903	1323	3055
	Sum of Number of Services, Raw	6845	8541	16632	32018
	Sum of Amount Paid, Raw	\$ 409,105.60	\$ 698,631.33	\$ 933,295.30	\$ 2,041,032.23
12 = Skin (codes 678-709)	Sum of Number of Visits, Raw	1003	1190	1286	3479
	Sum of Number of Services, Raw	5899	8761	23084	37744
	Sum of Amount Paid, Raw	\$ 157,258.79	\$ 188,892.15	\$ 189,981.74	\$ 536,132.68
13 = Musculoskeletal (codes 710-739)	Sum of Number of Visits, Raw	5054	7232	6527	18813
	Sum of Number of Services, Raw	21561	24960	39302	85823
	Sum of Amount Paid, Raw	\$ 1,285,164.71	\$ 1,597,790.93	\$ 1,736,666.60	\$ 4,619,622.24
14 = Congenital Anomalies (codes 740-759)	Sum of Number of Visits, Raw	928	849	746	2523
	Sum of Number of Services, Raw	3547	5680	2171	11398
	Sum of Amount Paid, Raw	\$ 188,760.14	\$ 228,268.91	\$ 193,202.90	\$ 610,231.95
15 = Prenatal (codes 760-779)	Sum of Number of Visits, Raw	503	390	558	1451
	Sum of Number of Services, Raw	1007	1045	1219	3271
	Sum of Amount Paid, Raw	\$ 167,586.48	\$ 144,333.43	\$ 155,855.63	\$ 467,775.54
16 = Ill-defined (codes 780-799)	Sum of Number of Visits, Raw	7695	9335	10487	27517
	Sum of Number of Services, Raw	69064	89404	84534	243002
	Sum of Amount Paid, Raw	\$ 4,125,582.88	\$ 4,980,245.59	\$ 4,924,849.45	\$ 14,030,677.92
17 = Injury & Poisoning (codes 800-999)	Sum of Number of Visits, Raw	3180	4734	4894	12808
	Sum of Number of Services, Raw	16954	29783	21051	67788
	Sum of Amount Paid, Raw	\$ 1,054,934.41	\$ 1,415,330.09	\$ 1,273,395.28	\$ 3,743,659.78
18 = Supplementary Classifications (Codes V**)	Sum of Number of Visits, Raw	4326	3903	5431	13660
	Sum of Number of Services, Raw	24241	28288	23840	76369
	Sum of Amount Paid, Raw	\$ 515,482.75	\$ 590,590.51	\$ 691,863.63	\$ 1,797,936.89
Total Sum of Number of Visits, Raw		65200	71234	75576	212010
Total Sum of Number of Services, Raw		296507	414893	397331	1108731
Total Sum of Amount Paid, Raw		\$ 13,750,890.59	\$ 16,906,865.97	\$ 17,294,295.61	\$ 47,952,052.17

Table 7.

Comparative chart of local healthcare facilities and services provided.

Services:	Healthcare Facility			
	Irwin Army Community Hospital	Geary Community Hospital	Mercy Regional Hospital	Manhattan Surgical Center
Cardiology Clinic		X		
Dermatology Clinic	X	X		
Dialysis (Full-time kidney dialysis)		X		
Ear, Nose, and Throat clinic	X	X		
Ear, Nose, and Throat surgery		X	X	X
Neurology Clinic		X		
Allergy/Immunization Clinics	X			
Ambulatory Surgery Center	X		X	
Anesthesia	X	X	X	
Audiology Clinic	X	X		
Behavioral Health	OUT PNT		X	
Cardiopulmonary		X	X	
Department of Pathology & Laboratory	X	X	X	
Department of Radiology	X	X	X	
Dermatology	X			
Emergency Department	X	X	X	
Home Health		X		
Home Medical Equipment		X		
Home Medical Services		X	X	
Inpatient Rehabilitation	LIMITED	X	X	
Inpatient Ward	X	X	X	
Intensive Care Unit		X	X	
Nutrition Care	X	X	X	
Obstetrics & Gynecology Service	X	X	X	SURGICAL
Occupational Health	X	X	X	
Occupational Therapy	X	X		
Oncology (Chemotherapy treatments only)		X		
Ophthalmology Clinic	X	X		
Ophthalmology Surgical		X		
Optometry Clinic	X			
Oral and Maxillofacial Surgery Service	X			
Orthopaedic Clinic	X			
Orthopaedic Surgery				X
Otolaryngology – Head/Neck Service	X			
Pain Management			X	
Pediatric Cardiology		X		
Pharmacy	X		X	
Physical Therapy Clinic	X	X		
Podiatry Clinic	X			
Podiatry Surgery				X
Preventive Medicine Service	X			
Primary Care Clinics (Family Practice, Pediatrics and Internal Medicine)	X	X	X	
Radiology	X	X	X	
Respiratory Therapy	X	X		
Sleep Disorder Services		X	X	
Social Work Services	X	X	X	
Special Care Unit (SCU and Post-Anesthesia)	X	X	X	
Surgical Services	X	X	X	
Surgical Weight Loss		X	X	
Urology Clinic		X		
Urology Surgery		X	X	X

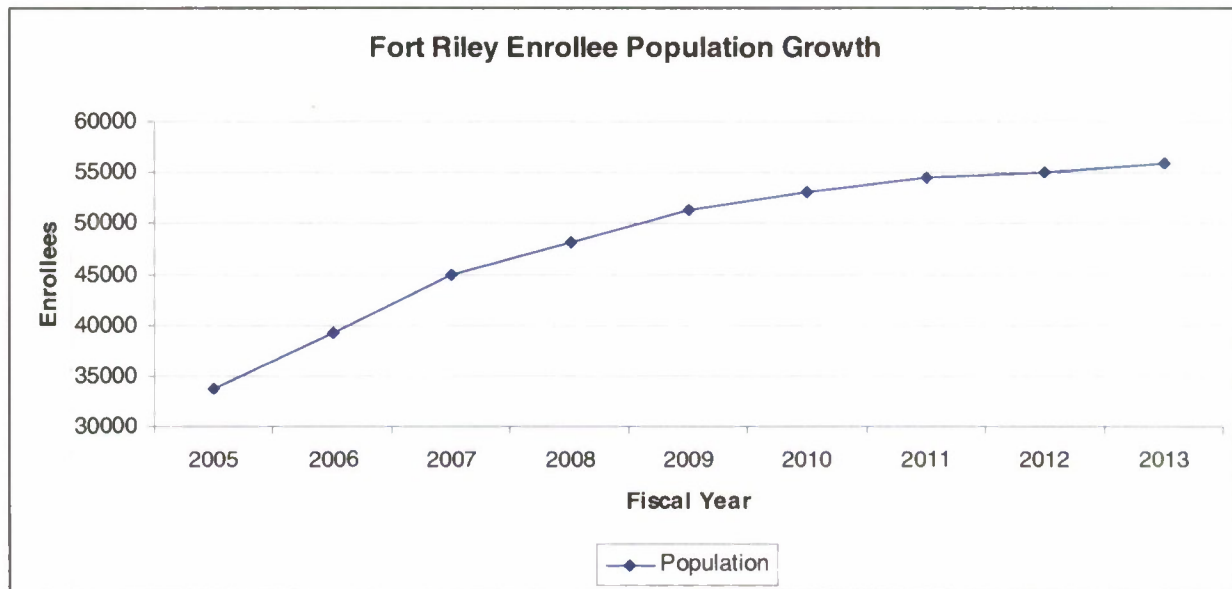


Figure 1. Enrollee population increase by fiscal year. Projection starts at the 2005 BRAC enrollee population and ends with the 2013 projected population.

$$A + B + C*2.5 + D + E + F*2.5 + G$$

A =	B =	C =	D =	E =	F =	G =
TRICARE Prime Enrolled Age 0-17	TRICARE Prime Enrolled Age 18-64	TRICARE Prime Enrolled Age 65+	Non-Prime Users Age 0-17 3 or more visits	Non-Prime Users Age 18-64 3 or more visits	Non-Prime Users Age 65+ 3 or more visits	AD Trainees
SOURCE: DEERS (M2)	SOURCE: DEERS (M2)	SOURCE: DEERS (M2)	SOURCE: SADR	SOURCE: SADR	SOURCE: SADR	SOURCE: TRADOC (DCSRM)

Figure 2. Population model formula for Primary Care. A, B & C include projected adjustments in the enrolled population for the effective date of the TDA.

$$A + B + C*2.5 + D + E + F*2.5 + G + H + I + J*2.5$$

A =	B =	C =	D =	E =	F =	G =	H =	I =	J =
TRICARE Prime Enrolled Age 0-17	TRICARE Prime Enrolled Age 18-64	TRICARE Prime Enrolled Age 65+	Non-Prime Users Age 0-17 3 or more visits	Non-Prime Users Age 18-64 3 or more visits	Non-Prime Users Age 65+ 3 or more visits	AD Trainees	Enrolled Elsewhere Users Age 0-17 3 or more Visits	Enrolled Elsewhere Users Age 18-64 3 or more Visits	Enrolled Elsewhere Users Age 65+ 3 or more Visits
SOURCE: DEERS (M2)	SOURCE: DEERS (M2)	SOURCE: DEERS (M2)	SOURCE: SADR	SOURCE: SADR	SOURCE: SADR	SOURCE: TRADOC (DCSRM)	SOURCE: SADR	SOURCE: SADR	SOURCE: SADR

Figure 3. Population model formula for specialty care. A, B & C include projected adjustments in the enrolled population for the effective date of the TDA.

(ASAM III)
POPULATION BASED PROVIDER REQUIREMENTS
FORT RILEY MEDDAC

		CLIN SERVICE	CURRENTLY OFFERED	1 PROV PER	SUPPORT PER	FY2006 POP	ROUNDING FACTOR	ROUNDED EARNED PROVIDER	EARNED SUPPORT	ROUNDED EARNED SUPPORT
			Y=YES, N=NO	POP OF	PROVIDER	33650				
SPECIALITY	AOC									
A	B	C	D	E	F	G	H	I	J	
PULMONARY DISEASE	60F	N	40000	2.40	0.841	0.75	1	2.400	2	
GASTROENTEROLOGY	60G	N	40000	2.40	0.841	0.75	1	2.400	2	
CARDIOLOGY	60H	N	30000	2.00	1.122	0.75	1	2.000	2	
PEDIATRIC CARDIOLOGY	60Q	N	90000	2.30	0.000	0.75	0	0.000	0	
DERMATOLOGY	60L	Y	35000	2.30	0.961	0.75	1	2.300	2	
ALLERGY	60M	Y	60000	2.40	0.000	0.67	0	0.000	0	
NEPHROLOGY	61A	N	60000	2.30	0.000	0.95	0	0.000	0	
HEMATOLOGY-ONCOLOGY	61B	N	40000	2.30	0.841	0.90	0	0.000	0	
ENDOCRINOLOGY	61C	N	60000	2.30	0.000	0.75	0	0.000	0	
RHEUMATOLOGY	61D	N	50000	2.40	0.000	0.75	0	0.000	0	
INFECTIOUS DISEASE	61G	N	50000	2.40	0.000	0.75	0	0.000	0	
NEUROLOGY	60V	N	30000	2.40	1.122	0.80	1	2.400	2	
CHILD NEUROLOGY	60R	N	90000	2.40	0.000	0.75	0	0.000	0	
PSYCHIATRY	60W	Y	18000	1.20	1.869	0.75	2	2.400	2	
CHILD PSYCHIATRY	60U	N	60000	1.20	0.000	0.75	0	0.000	0	
GENERAL SURGERY	61J	Y	12500	2.30	2.692	0.50	3	6.900	7	
THORACIC-CARDIAC	61K	N	50000	3.00	0.000	0.90	0	0.000	0	
PLASTIC SURGERY	61L	N	60000	2.30	0.000	0.75	0	0.000	0	
ORTHOPEADIC	61M	Y	14285	2.30	2.356	0.50	2	4.600	5	
PHYSICAL MEDICINE	61P	N	50000	2.30	0.000	0.90	0	0.000	0	
PERIPHERAL VASCULAR	61W	N	60000	2.30	0.000	0.75	0	0.000	0	
OPHTHALMOLOGY	60S	Y	25000	2.30	1.346	0.75	1	2.300	2	
OTOLARYNGOLOGY	60T	Y	28000	2.30	1.202	0.75	1	2.300	2	
UROLOGY	60K	N	30000	2.30	1.122	0.75	1	2.300	2	
NEUROSURGERY	61Z	N	70000	2.30	0.000	0.66	0	0.000	0	
OB/GYN	60J	Y	11000	3.00	3.059	0.67	3	9.000	9	
RADIATION THERAPY	61Q	N	75000	2.40	0.000	0.90	0	0.000	0	
NUCLEAR MEDICINE	60B	N	75000	3.50	0.000	0.67	0	0.000	0	
EMERGENCY MEDICINE	62A	Y	12500	4.50	2.692	0.75	2	9.000	9	
INTERNAL MEDICINE	61F	Y	20000	2.30	1.683	0.50	2	4.600	5	
PEDIATRICS	60P	Y	25000	2.30	1.346	0.50	1	2.300	2	
FAMILY PRACTICE	61H	Y	11000		0.581	0.50	1			
OPTOMETRY	67F	Y	8100	2.00	4.154	0.75	4	8.000	8	
PHYSICAL THERAPY	65B	Y	7500	TABLE	4.487	0.67	4			
OCCUPATIONAL THERAPY	65A	Y	18000	TABLE	1.869	0.67	2			
PODIATRY	67G	Y								
AUDIOLOGY	72C	Y	0	0.00	0.000	0.00	0	0.000	0	
SPEECH	CIV	N								
PSYCHOLOGY	73B	Y	9000	0.75	3.739	0.75	0	3.000	0	
ALCOHOL & SUB ABUSE	CIV	Y								
SOCIAL WORK	73A	Y								
RADIOLOGY	61R	Y								
PATHOLOGY	61U	Y								
PHARMACY	67E	Y								
NUTRITION	65C	Y								
ANESTHESIA	60N / 66F	Y								
PRIMARY CARE					29165					
FP , IM, PEDS	61H 61F 60P	Y	1178	2.80	24.758	0.500	70	70.000	70	
TOTALS							63		136	
NON-AOC SUBSPECIALISTS										
NEONATOLOGY			N				0			
PEDIATRIC ****					33650					
(**** DEV PEDS, PULMONARY, GASTRO, HEM-ONC, ENDO, NEPHRO, ORTHO, PED SURG)			120000	1.00	2.804	0.80	3	3.000	3	

Figure 4. Automated Staffing Assessment Model (ASAM III) FY06

(ASAM III)
POPULATION BASED PROVIDER REQUIREMENTS
FORT RILEY MEDDAC

		CLIN SERVICE		1 PROV	SUPPORT	FY 2013		ROUNDED		ROUNDED
		CURRENTLY		PER	PER	POP		EARNED		EARNED
		OFFERED						PROVIDER		SUPPORT
		Y=YES, N=NO		POP OF	PROVIDER	55733		FACTOR		SUPPORT
SPECIALITY	AOC									
A	B	C		D	E	F		G	H	I
PULMONARY DISEASE	60F	N		40000	2.40	1.393		0.75	1	2.400
GASTROENTEROLOGY	60G	N		40000	2.40	1.393		0.75	1	2.400
CARDIOLOGY	60H	N		30000	2.00	1.858		0.75	2	4.000
PEDIATRIC CARDIOLOGY	60Q	N		90000	2.30	0.000		0.75	0	0.000
DERMATOLOGY	60L	Y		35000	2.30	1.592		0.75	1	2.300
ALLERGY	60M	Y		60000	2.40	0.929		0.67	1	2.400
NEPHROLOGY	61A	N		60000	2.30	0.929		0.95	0	0.000
HEMATOLOGY-ONCOLOGY	61B	N		40000	2.30	1.393		0.90	1	2.300
ENDOCRINOLOGY	61C	N		60000	2.30	0.929		0.75	1	2.300
RHEUMATOLOGY	61D	N		50000	2.40	1.115		0.75	1	2.400
INFECTIOUS DISEASE	61G	N		50000	2.40	1.115		0.75	1	2.400
NEUROLOGY	60V	N		30000	2.40	1.858		0.80	2	4.800
CHILD NEUROLOGY	60R	N		90000	2.40	0.000		0.75	0	0.000
PSYCHIATRY	60W	Y		18000	1.20	3.096		0.75	3	3.600
CHILD PSYCHIATRY	60U	N		60000	1.20	0.929		0.75	1	1.200
GENERAL SURGERY	61J	Y		12500	2.30	4.459		0.50	4	9.200
THORACIC-CARDIAC	61K	N		50000	3.00	1.115		0.90	1	3.000
PLASTIC SURGERY	61L	N		60000	2.30	0.929		0.75	1	2.300
ORTHOPEADIC	61M	Y		14285	2.30	3.902		0.50	4	9.200
PHYSICAL MEDICINE	61P	N		50000	2.30	1.115		0.90	1	2.300
PERIPHERAL VASCULAR	61W	N		60000	2.30	0.929		0.75	1	2.300
OPHTHALMOLOGY	60S	Y		25000	2.30	2.229		0.75	2	4.600
OTOLARYNGOLOGY	60T	Y		28000	2.30	1.990		0.75	2	4.600
UROLOGY	60K	N		30000	2.30	1.858		0.75	2	4.600
NEUROSURGERY	61Z	N		70000	2.30	0.796		0.66	1	2.300
OB/GYN	60J	Y		11000	3.00	5.067		0.67	5	15.000
RADIATION THERAPY	61Q	N		75000	2.40	0.000		0.90	0	0.000
NUCLEAR MEDICINE	60B	N		75000	3.50	0.000		0.67	0	0.000
EMERGENCY MEDICINE	62A	Y		12500	4.50	4.459		0.75	4	18.000
INTERNAL MEDICINE	61F	Y		20000	2.30	2.787		0.50	3	6.900
PEDIATRICS	60P	Y		25000	2.30	2.229		0.50	2	4.600
FAMILY PRACTICE	61H	Y		11000		0.963		0.50	1	
OPTOMETRY	67F	Y		8100	2.00	6.881		0.75	7	14.000
PHYSICAL THERAPY	65B	Y		7500	TABLE	7.431		0.67	7	
OCCUPATIONAL THERAPY	65A	Y		18000	TABLE	3.096		0.67	3	
PODIATRY	67G	Y								
AUDIOLOGY	72C	Y		0	0.00	0.000		0.00	0	0.000
SPEECH	61V	N								
PSYCHOLOGY	73B	Y		9000	0.75	6.193		0.75	6	4.500
ALCOHOL & SUB ABUSE	61V	Y								
SOCIAL WORK	73A	Y								
RADIOLOGY	61R	Y								
PATHOLOGY	61U	Y								
PHARMACY	67E	Y								
NUTRITION	65C	Y								
ANESTHESIA	60N / 66F	Y								
PRIMARY CARE						54420				
FP , IM, PEDS	61H,61F,60P	Y		1178	2.80	46.197		0.500	46	128.800
						TOTALS			119	

Figure 5. Automated Staffing Assessment Model (ASAM III) FY 13

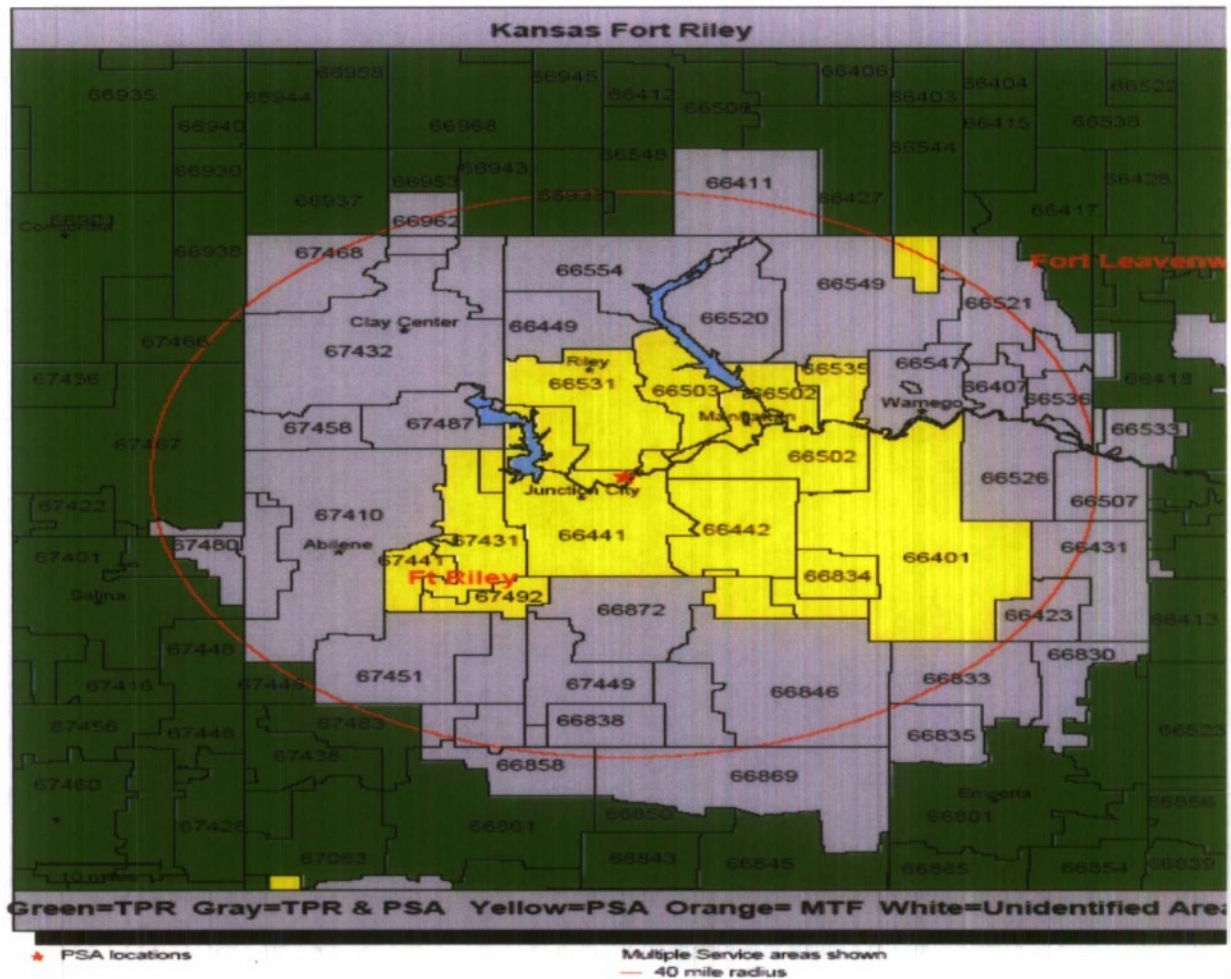


Figure 6. Fort Riley's enrollment zip code map (TRICARE, 2007). The oval represents the 40 mile catchment area radius.

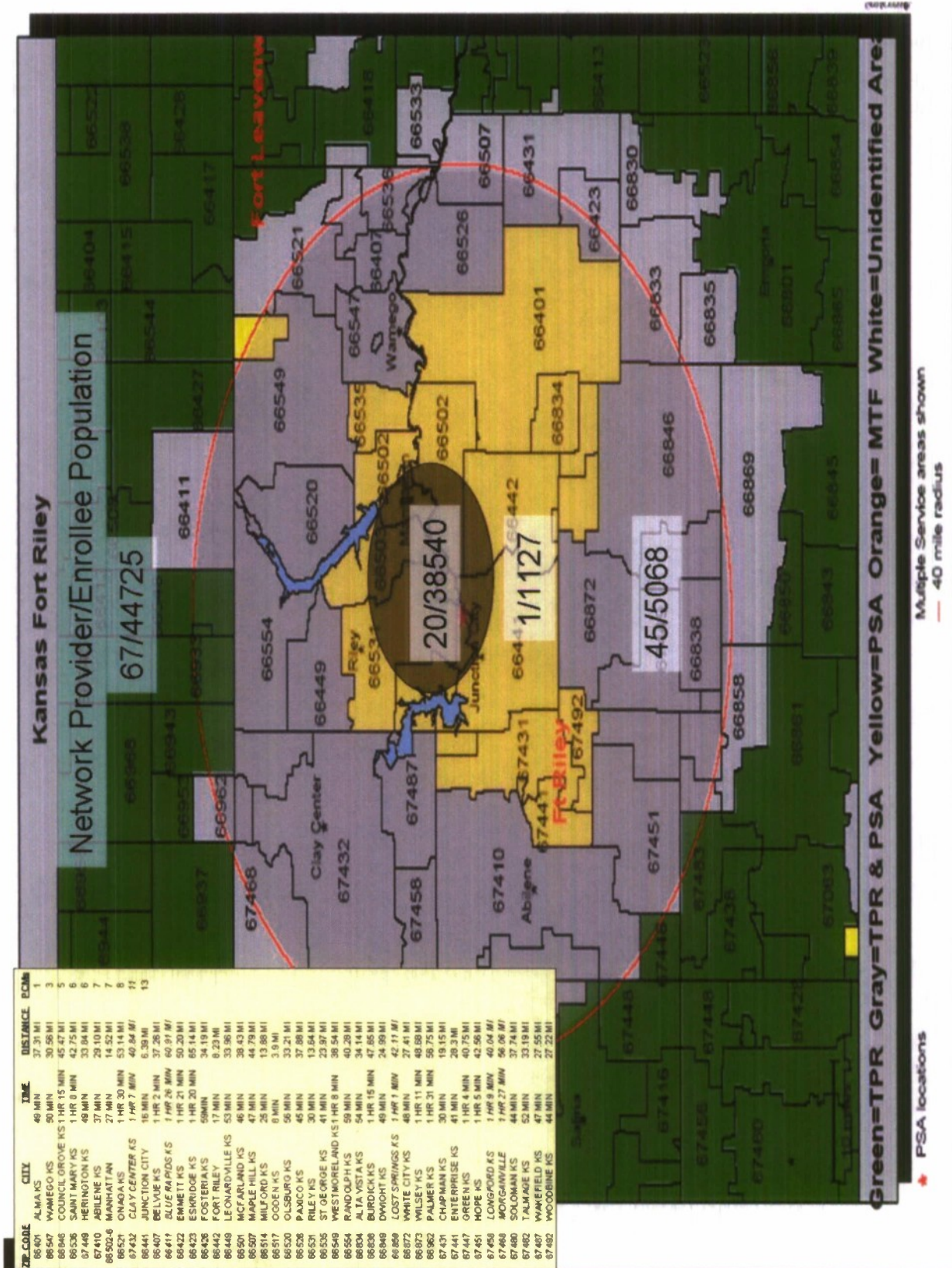


Figure 7. Primary Care network provider participation map.

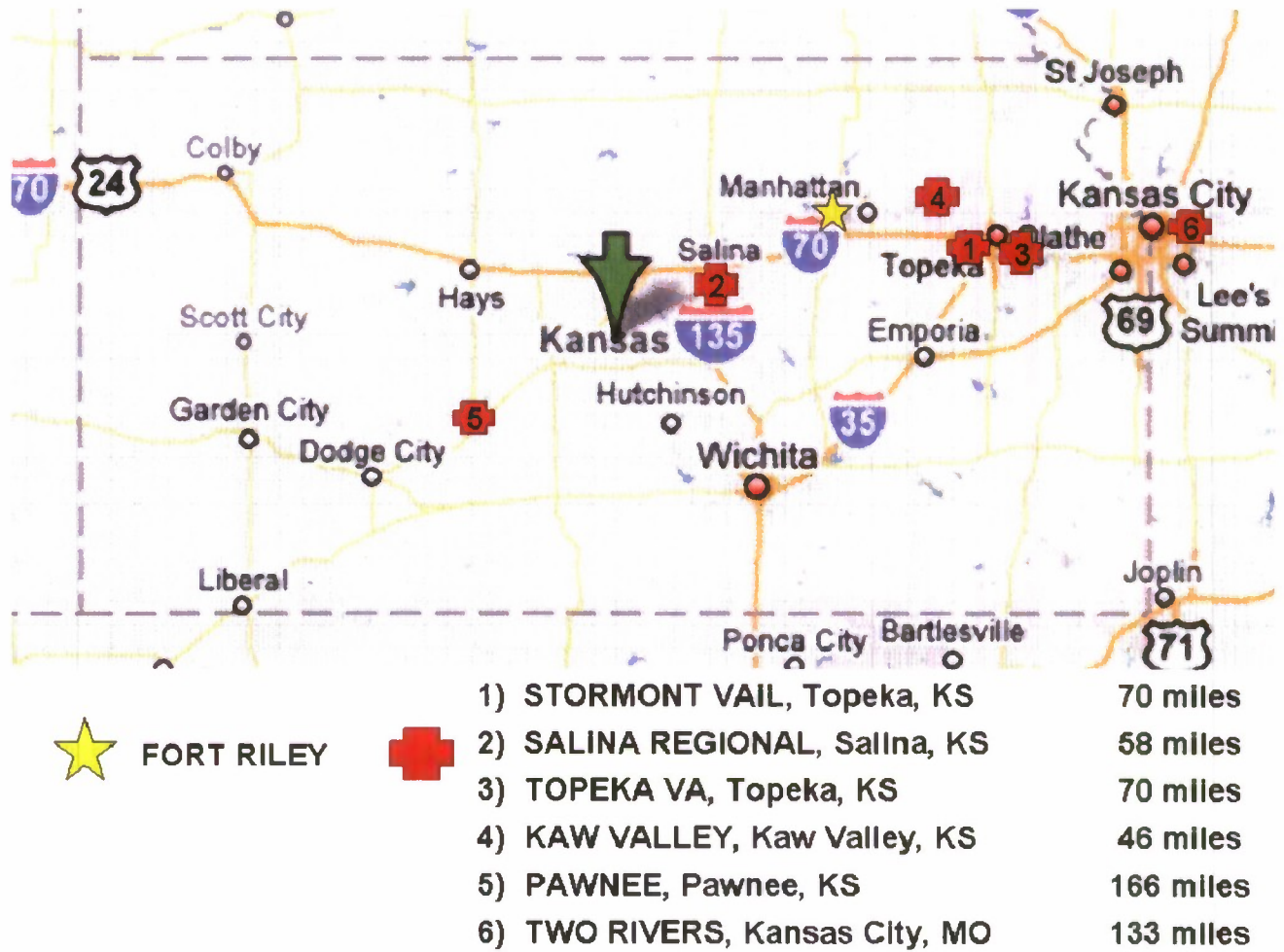
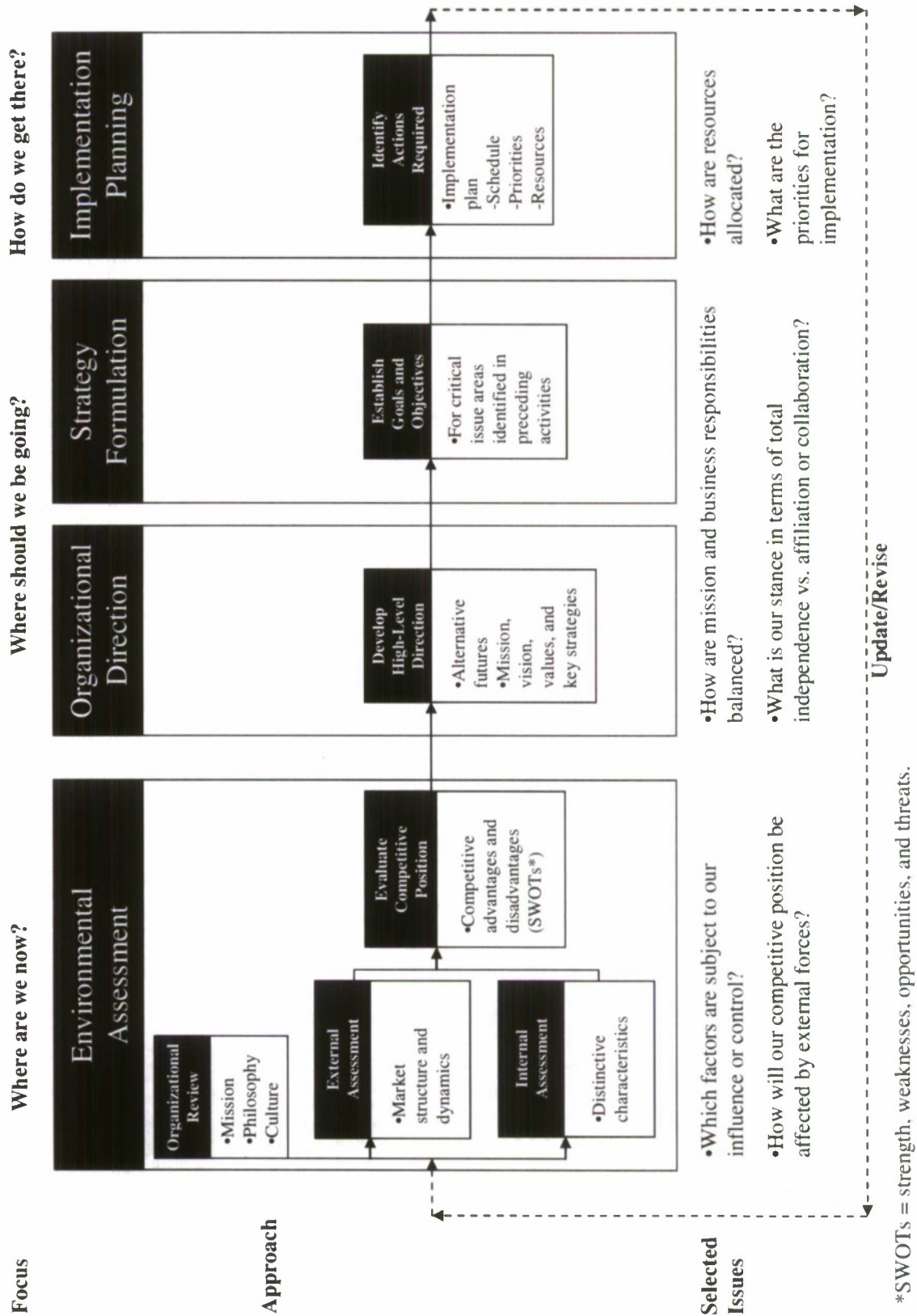


Figure 8. Inpatient Mental Health utilized by IACH (Map and Distance).

Appendix A.

Strategic Planning Approach



Appendix B.

PESTLE Analysis

<u>Category</u>	<u>Factors</u>
Political	<ul style="list-style-type: none"> • Warrior in Transition Unit Emphasis • Congressional Level: <ul style="list-style-type: none"> o TRICARE Reimbursement Rates o New Hospital o Policies/Laws o High cost purchases
Economic	<ul style="list-style-type: none"> • Reimbursement Rates • Prospective Payment System • Performance Based Assessment Model • Cost of travel to receive healthcare • Provider pay levels • Different funding sources for different projects/initiatives
Social	<ul style="list-style-type: none"> • Community relations between military and civilian communities • Perception of the quality of care • Customer satisfaction • Access to care standards
Technological	<ul style="list-style-type: none"> • Increased ability to conduct more services <ul style="list-style-type: none"> o Lap-Band o Lasik o Orthopedics • Increased range of ages that will be available to have services provided for
Legal	<ul style="list-style-type: none"> • Limits ability to <ul style="list-style-type: none"> o Hire in a timely manner o Establish competitive pay scales o Conduct direct negotiations o Build and renovate in a timely manner o Fund identified/ needed projects
Environmental	<ul style="list-style-type: none"> • Rural Kansas • 50+ year old Hospital • Limited local healthcare support structure • Limited specialties (military and civilian) • Increased travel distances and times to receive needed healthcare services

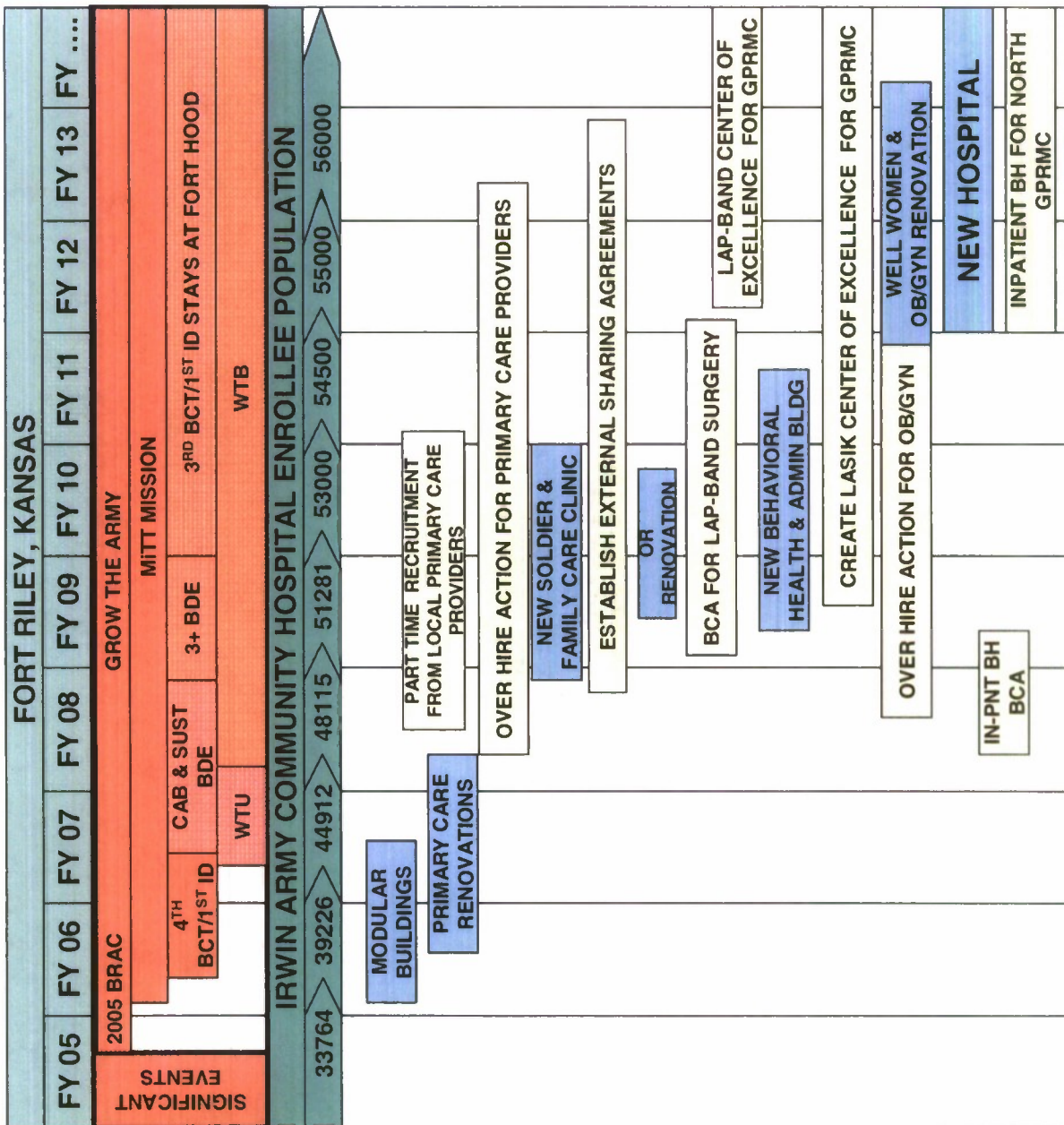
Appendix C.

SWOT Analysis

	Strengths <ul style="list-style-type: none"> • Provider productivity • Forecasting • Flexibility • Situational analysis • Lasik initiative • Renovations • Structural expansion 	Weaknesses <ul style="list-style-type: none"> • Provider levels • Availability of specialties in the network • Old facility • Limited local network • Low reimbursement rates
Opportunities <ul style="list-style-type: none"> • Surgical procedures • Expand Primary Care Clinics • Recapture of purchased care • In/outpatient Mental Health Services 	<i>[How do I use these strengths to take advantage of these opportunities?]</i> <ol style="list-style-type: none"> 1. Increase surgical scope of services provided 2. Provide Lasik services to other installation's military enrollees within GPRMC 3. Increase the number of Primary Care clinics 4. Expand Mental Health outpatient services 	<i>[How do I overcome the weaknesses that prevent me taking advantage of these opportunities?]</i> <ol style="list-style-type: none"> 1. Create inpatient Mental Health ward 2. Establish services not able to be done in local network 3. Renovate current services' areas to assist in the recapture of purchased care work load 4. Create agreements with community to provide services needed
Threats <ul style="list-style-type: none"> • Increasing population • Funding • Politics • Inability to hire providers • Saturated network • Increased utilization rate of WTU members 	<i>[How do I use these strengths to reduce the likelihood and impact of these threats?]</i> <ol style="list-style-type: none"> 1. Project upcoming FY provider levels and hire them prior to FY. 2. Actively over hire to mitigate the arrival to departure ratio of providers 3. Expand services to decrease the amount of purchased care 4. Expand provider to WTU ratio 	<i>[How do I address the weaknesses that will make these threats a reality?]</i> <ol style="list-style-type: none"> 1. Actively and continuously request funding for over hire positions 2. Contact rural providers within catchment area to work part time 3. Congressional approval for a new hospital 4. Congressional review and change to current reimbursement rates

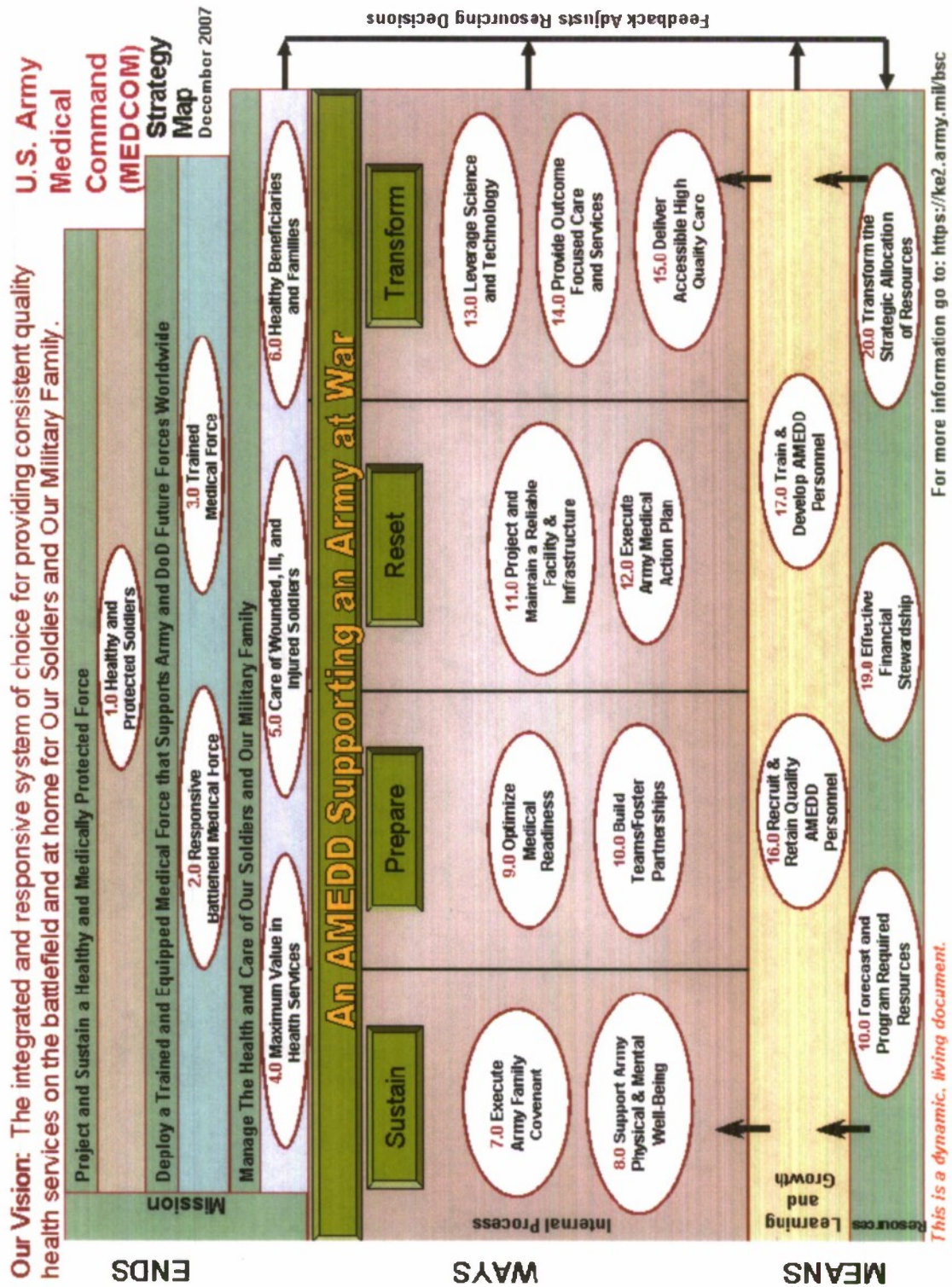
Appendix D.

IACH Potential Strategies Map



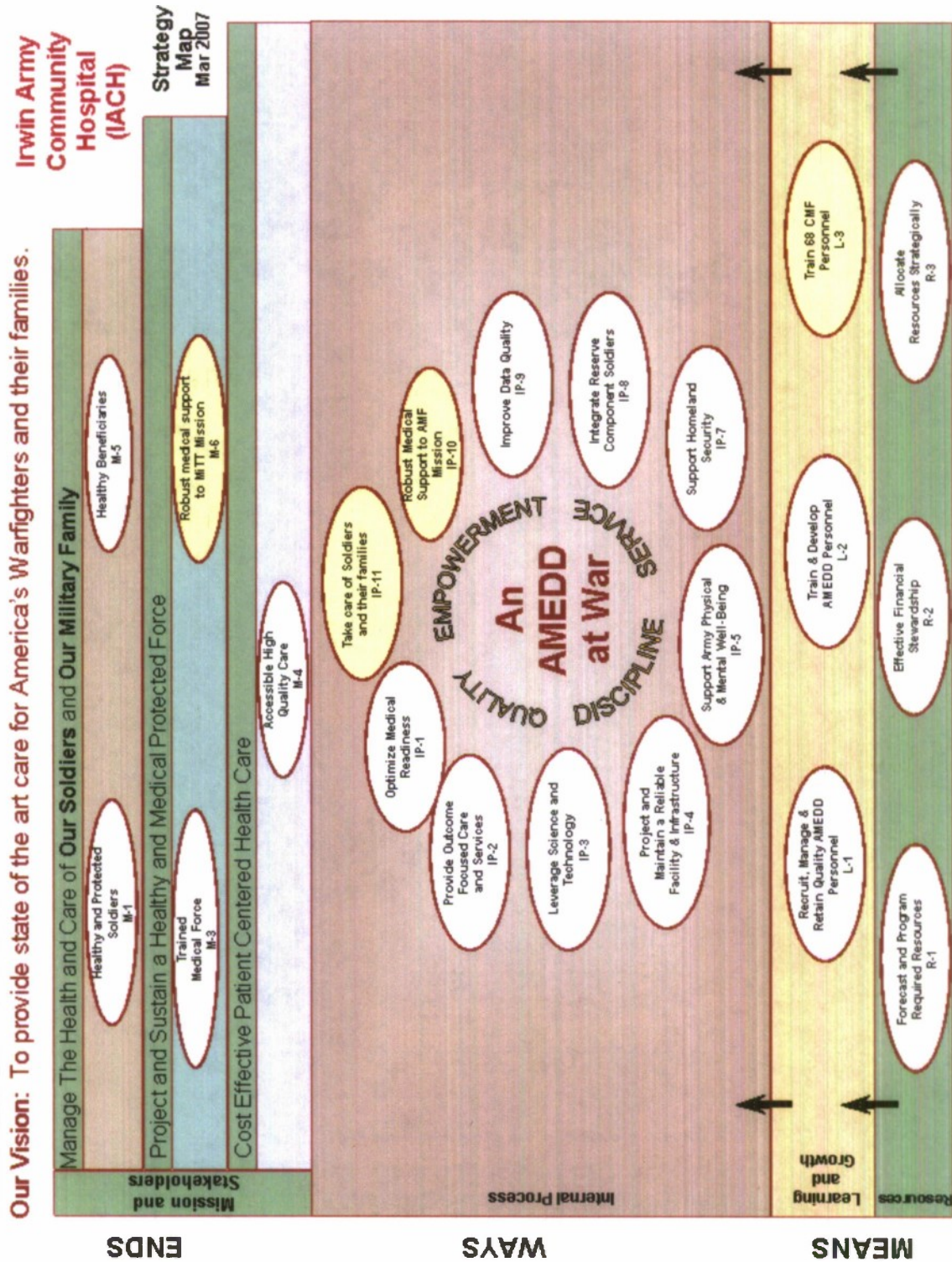
Appendix E.

MEDCOM Strategy Map



Appendix F

Irwin Army Community Hospital Strategy Map



Appendix G.

Balanced Scorecard

Irwin Army Community Hospital Balanced Scorecard (As of:27 April 2007)

IACH Vision: To provide state of the art care for America's Warfighters and their families.				
IACH's 3 Missions:				
1 – Manage the Health and Care of Our Soldiers and Our Military Family.				
2 – Project and Sustain a Healthy and Medical Protected Force				
3 – Cost Effective Patient Centered Health Care				
IACH Objectives and Metric No.	Objective Statement	IACH Measures	IACH Targets	Staff Proponent
Healthy and Protected Soldiers M-1	Improve the health of service members, prepare them for deployment, prevent casualties and provide high quality and responsive combat casualty care to injured Soldiers on end of the battlefield. Provide preventive health techniques and emerging technologies in environmental surveillance and combat health services to protect all service members before, during, and after deployment.	M-1a: Implementation of Clinical Management Guidelines (CMGs) - TBD M-1b1: Percent of enrolled women with current mammography M-1c1: Percent of Soldiers referred for vision appointments from the SRP site who are seen within 48 hours M-1c2: Percent of available refractive surgery appointments utilized by deploying Soldiers M-1d: Percent total Asthmatic patients with moderately persistent to severe persistent diagnosis who are on long term controllers	M-1a: TBD M-1b1: 90% M-1c1: 95% M-1c2: 90% M-1d: >= 90%	M-1a: DCCS M-1b1: M-1c1: SRP/ EENT M-1c2: M-1d: Clin ops
Trained Medical Force M-3	Provide a preeminent medical force that supports full spectrum operations and joint force requirements.	M-3a1: Percent of 68Ws NREMT certified M-3a2: Percent AC 68Bs and 68Cs transitioned to 68W against program objectives (IACH and Fort Riley) having received required 68W sustainment training (SACMS-VT) M-3b1: Percent of deploying PROFIS health care providers that receive trauma management training within 1 year of deployment. M-3b2: Percent PROFIS soldiers deployable and current in all AR 600-8-101 medical requirements, required training, weapons qualification, and collective training with their assigned or like unit. M-3b3: Percent of IACH PROFIS personnel completing reintegration training	M-3a1: 100% M-3a2: 100% of transition target M-3a3: 98% of 68Ws with sustainment training within 6 months M-3b1: 100% M-3b2: 90% M-3b3: 100%	M-3a1: EPD M-3a2: EPD M-3a3: EPD M-3b1: PTMS M-3b2: PTMS M-3b3: Medical Company/ PTMS/Personnel
Accessible High Quality Care M-4	Improve access to care by maximizing capacity, decreasing inappropriate utilization, simplifying the appointment process and improving patient management.	M-4a1a: Percent of Acute Appointments Meeting Access Standards M-4a1b: Percent of acute/ OPAC appointments meeting access standards M-4a1c: Percent of routine appointments meeting access standards M-4a1d: Percent wellness appointments meeting access standards M-4a2: Percent Patient Satisfaction with Access (APLSS questions 9-14) M-4a3: Percent Patient Satisfaction (APLSS questions 1-9) M-4a4a: Percent patient satisfaction with time between schedule and visit (APLSS top 3 dissatisfiers) M-4a4b: Percent patient satisfaction with wait time. (APLSS top 3 dissatisfiers) M-4a4c: Percent patient satisfaction with overall pharmacy experience (APLSS top 3 dissatisfiers) M-4a5: Percent provider schedules available for booking 30 days in advance M-4a6: Percent of IACH specialty care referrals seen within 30 days M-4a7: Percent of enrollees satisfied with making appointments by phone	M-4a1a: 90% M-4a1b: 90% M-4a1c: 90% M-4a1d: 90% M-4a2: 75% M-4a3: 90.7% M-4a4a: 69.4% M-4a4b: 66.9% M-4a4c: 70% M-4a5: 95% M-4a6: 90% M-4a7: 84%	M-4a1a: CLIN OPS M-4a1b: CLIN OPS M-4a1c: CLIN OPS M-4a1d: CLIN OPS M-4a2: Customer Service M-4a3: Customer Service M-4a4a: Customer Service M-4a4b: Customer Service M-4a4c: Customer Service M-4a5: CLIN OPS M-4a6: CLIN OPS M-4a7: CLIN OPS
	Provide the right person/practitioner doing the right things safely the first time, to the right person, with care and respect.	M-4b1: Percent of final "time out" observed by direct observation (Joint Commission Universal Protocol Compliance) M-4b2: Percent of medical records that have reconciled medications on admission (NPSG 8A)	M-4b1: >= 90% M-4b2: >= 90%	M-4b1: Dept Surgery/ Patient Safety M-4b2: PAD/ Patient Safety
	Ensure continuous survey/inspection readiness resulting in full accreditation in every program.	M-4c1a: Percent of patients for whom two identifiers are used when taking blood samples, administering medications or blood products or labeling specimens. (NPSG 1A) M-4c1b: Percent of verbal or telephonic orders and critical test results with documented or observed "read-back" verification by the person receiving the order or test result. (NPSG 2A) M-4c1c: Percent of handwritten charts and handwritten prescriptions that adhere to excluding the JCAHO-recommended and facility-selected abbreviations, acronyms and symbols. (NPSG 2B) M-4c1d: Percent of all medications, medication containers (ie, syringes, medicine cups, basins), or other solutions on and off the sterile field that are labeled. (NPSG 3D) M-4c1a: Percent of compliance with CDC hand-washing guidelines. (NPSG 7A) M-4c1t: Percent of at-risk patients evaluated for potential of fall (NPSG 9B) M-4c1g: NPSG 13A pending response from JCAHO SIG M-4c1h: NPSG 15A pending response from JCAHO SIG M-4c2: Percent of Sentinel Events (to include nosocomial related deaths) reported as required and for which Root Cause Analyses are completed and recommended changes implemented. M-4c3: Number of repeat Sentinel Events since the Root Cause Analysis on the first occurrence. M-4d1: Full accreditation with Joint Commission	M-4c1a: 100% M-4c1b: 100% M-4c1c: 100% M-4c1d: 100% M-4c1a: 100% M-4c1f: 100% M-4c1g: 100% M-4c1h: 100% M-4c2: 100% M-4c3: 0% M-4d1: 100%	M-4c1a: Patient Safety M-4c1b: Patient Safety M-4c1c: Patient Safety M-4c1d: Patient Safety M-4c1a: Patient Safety M-4c1f: Patient Safety M-4c1g: Patient Safety M-4c1h: Patient Safety M-4c2: Patient Safety M-4c3: Patient Safety M-4d1: Mr. Foreman
Healthy Beneficiaries M-5	Provide for the health needs of defined populations through cost effective, evidence-based, disease management, demand management, and public health programs.	M-5a: Annual rate of mumps among IACH healthcare beneficiaries. M-5b: Percentage of skin and soft tissue infections due to community-acquired MRSA that recur. M-5c1: Percentage of diabetes patients who have had a yearly HBA1c M-5c2: Percentage of diabetes patients with HBA1c below 9	M-5a: <= 3/100,000 M-5b: <= 3% individual/ 6% family M-5c1: 90% M-5c2: > 90%	M-5a: Preventive Med M-5b: Preventive Med M-5c1 M-5c2
Robust support to MITT Mission M-6	Provide responsive and flexible medical support to the Fort Riley MITT Mission	M-6a: Percent of MITT Soldiers seen within four days (referral to appointment) M-6b: % MITT Soldiers that deploy with complete medical SRP packages M-6c: % MITT Soldiers missing initial deployment movement awaiting healthcare clearances M-6d: % medical supply needs filled for MITT teams	M-6a: 90% M-6b: 100% M-6c: 0% M-6d: 90%	M-6a: Clin Ops M-6b: SRP M-6c: Clin Ops M-6d: Logistics

Optimize Medical Readiness IP-1	Ensure health readiness of the force.	<p>IP-1a1: Percent of installation Soldiers who are medically ready in MEDPROS (Not pregnant)</p> <p>IP-1a2: Percent of installation Soldiers who are medically ready in MEDPROS (Medically non-deployable)</p> <p>IP-1a3: Percent of installation Soldiers who are medically ready in MEDPROS (DNA)</p> <p>IP-1a4: Percent of installation Soldiers who are medically ready in MEDPROS (Dental)</p> <p>IP-1a5: Percent of installation Soldiers who are medically ready in MEDPROS (HIV screen)</p> <p>IP-1a6: Percent of installation Soldiers who are medically ready in MEDPROS (immunizations)</p> <p>IP-1a7: Percent of installation Soldiers who are medically ready in MEDPROS (No limited duty profile)</p> <p>IP-1a8: Percent of installation Soldiers who are medically ready in MEDPROS (PHA)</p> <p>IP-1b: Percent of SRP/RSRP requirements successfully met</p> <p>IP-1c: Percent of deploying soldiers with completed DD2795</p> <p>IP-1d: Percent of end-of-deployment soldiers with completed and submitted DD2795</p>	<p>IP-1a1: 90%</p> <p>IP-1a2: 90%</p> <p>IP-1a3: 90%</p> <p>IP-1a4: 90%</p> <p>IP-1a5: 90%</p> <p>IP-1a6: 90%</p> <p>IP-1a7: 90%</p> <p>IP-1a8: 90%</p> <p>IP-1b: 100%</p> <p>IP-1c: 100%</p> <p>IP-1d: 100%</p>	<p>IP-1a1: SRP</p> <p>IP-1a2: SRP</p> <p>IP-1a3: SRP</p> <p>IP-1a4: SRP</p> <p>IP-1a5: SRP</p> <p>IP-1a6: SRP</p> <p>IP-1a7: SRP</p> <p>IP-1a8: SRP</p> <p>IP-1b: SRP</p> <p>IP-1c: SRP</p> <p>IP-1d: SRP</p>
Provide Outcome Focused Care and Services IP-2	Provide effective outcome-focused care and services through the use of evidence-based practice, clinical practice guidelines, disease management, and LSS project deployments.	<p>IP-2a1: Percent MEB submitted to PEB within 90 days</p> <p>IP-2a2: Percent of MEB submitted to PEB returned to IACH</p> <p>IP-2b: Percent of women ages 21-64 with coded cervical cancer screening within the last 36 months</p> <p>IP-2c1: Percent of MHO on hand >270 days</p> <p>IP-2c2: Percent of MHO on hand >270 days for whom MEB has not been initiated</p> <p>IP-2c3: Percent of MHO who go to CBHCO and have to return to MTF</p> <p>IP-2d1: Percent of measured improvement as a result of each organizational-approved, patient outcome-based performance improvement project</p>	<p>IP-2a1: 90%</p> <p>IP-2a2: <10%</p> <p>IP-2b: >= 90%</p> <p>IP-2c1: 25% or less at IACH</p> <p>IP-2c2: 50% or less at IACH</p> <p>IP-2c3: <2%</p> <p>IP-2d1: >75% of each PI show measurable improvement</p>	<p>IP-2a1: PAD</p> <p>IP-2a2: PAD</p> <p>IP-2b: OB/GYN / Clin Ops</p> <p>IP-2c1: Case Management (Reserve)</p> <p>IP-2c2: Case Management (Reserve)</p> <p>IP-2c3: Case Management (Reserve)</p> <p>IP-2d1: Quality</p>
Leverage Science and Technology IP-3	Institutionalize the seamless use and life cycle management of secure, reliable, integrated, accessible, accurate, and user-friendly information systems to ensure quality patient care and conserve resources across a continuum of healthcare.	<p>IP-3a: Customer response time between order requirement (right item); order placement and shipment (right place); and order fulfillment (right time & right condition)</p> <p>IP-3b1: AHLTA sustainment training no-show rate</p> <p>IP-3b2: Percentage of outpatient visits documented in AHLTA</p> <p>IP-3c1: Number of minutes per quarter AHLTA is degraded</p> <p>IP-3c2: Number of minutes per quarter AHLTA has a complete outage</p>	<p>IP-3a: 90%</p> <p>IP-3b1: <5%</p> <p>IP-3b2: 95%</p> <p>IP-3c1: <5000 minutes</p> <p>IP-3c2: <189 minutes</p>	<p>IP-3a: Logistics</p> <p>IP-3b1: IMD</p> <p>IP-3b2: IMD</p> <p>IP-3c1: IMD</p> <p>IP-3c2: IMD</p>
Project and Maintain a Reliable Facility Infrastructure IP-4	<p>Project and maintain reliable facilities, installations, and information infrastructure that support emerging issues</p> <p>Impeccable population health care needs such as BRAC, IGPBS, and restoration. Improve facilities condition, capacity, and reliability through requirements based programming and investments to support the Tri-Service Business Plan and IACH mission. Project and maintain a reliable information infrastructure that supports current and future IACH missions.</p>	<p>IP-4a1: Number of critical system failures</p> <p>IP-4a2: Overall FCI rating</p> <p>IP-4a3: Percent of project value that results in FCI improvement</p> <p>IP-4a4: Facility Condition Index (FCI) Rating of Medical Facilities</p> <p>IP-4a5: Number of square feet slated for improvement (buildings >30 yrs old)</p> <p>IP-4a6: Percent of projects meeting population requirements within 12 months</p> <p>IP-4a7: Percent of BRAC projects on schedule (MILCON)</p> <p>IP-4b: Local Area Network Availability: uptime</p>	<p>IP-4a1: < previous FY</p> <p>IP-4a2: 7% improvement per annum</p> <p>IP-4a3: 40%</p> <p>IP-4a4: FCI of not less than 15, and not less than less than FY03</p> <p>IP-4a5: 5% / 20,000 per year</p> <p>IP-4a6: 100%</p> <p>IP-4a7: 100%</p> <p>IP-4b: >=96% uptime</p>	<p>IP-4a1: Facilities Management</p> <p>IP-4a2: Facilities Management</p> <p>IP-4a3: Facilities Management</p> <p>IP-4a4: Facilities Management</p> <p>IP-4a5: DCA/Facilities Management</p> <p>IP-4a6: DCA/Facilities Management</p> <p>IP-4a7: Facilities Management</p> <p>IP-4b: IMD</p>
Support Army Physical & Mental Well-Being IP-5	Support the physical and mental needs of each member of the Total Army Family.	<p>IP-5a: Percent of compliance with PDHRA screenings of eligible population</p> <p>IP-5b: Number of nutrition encounters outside of hospital per quarter</p> <p>IP-5c1: Percentage of enrolled Active Duty personnel who complete all four Tobacco Cessation Class sessions</p> <p>IP-5c2: Percentage of Active Duty personnel who are not smoking 6 months after completing the Tobacco Cessation Program</p>	<p>IP-5a: 95%</p> <p>IP-5b: 10% / 8 people increase</p> <p>IP-5c1: 75%</p> <p>IP-5c2: 75%</p>	<p>IP-5a: SRP</p> <p>IP-5b: Nutrition Care</p> <p>IP-5c1: Preventive Med</p> <p>IP-5c2: Preventive Med</p>
Support Homeland Security IP-7	Ensure IACH's ability to support HLS and emergency medical response operations in Fort Riley AO	<p>IP-7a1: Percent of standards within approved Emergency Management Plans (EMP) which meet MEDCOM Pam 525-1 and Joint Commission standards and have been rehearsed annually</p> <p>IP-7a2: Number of semi-annual MEMP exercises IAW MEDCOM Pam 525-1 and Joint Commission standards</p> <p>IP-7a3: Percent of personnel completed annual Anti-Terrorism (AT) awareness training</p> <p>IP-7a4: Percent of personnel having completed CBRNE training (every three years)</p> <p>IP-7a5: Percentage of duty positions on the DECON team that remain vacant for more than 30 days</p> <p>IP-7a6: Percentage of personnel on the DECON team who have received all the needed training within 3 months of assignment</p>	<p>IP-7a1: 100%</p> <p>IP-7a2: 100%</p> <p>IP-7a3: 90% (annual)</p> <p>IP-7a4: 100% of assigned eligible personnel</p> <p>IP-7a5: <= 10%</p> <p>IP-7a6: 90%</p>	<p>IP-7a1: EMP Committee and PTMS</p> <p>IP-7a2: EMP Committee and PTMS</p> <p>IP-7a3: EPD/ PTMS</p> <p>IP-7a4: EPD</p> <p>IP-7a5: ESO</p> <p>IP-7a6: ESO</p>
Integrate Reserve Component Soldiers IP-8	Ensure seamless integration of affiliated USAR Soldiers, and the medical support of Annual Training sites in IACH's geographical area of responsibility.	<p>IP-8a1: Percent aligned individual Mobilization Augmentation (IMA) positions with MOS/OA/OOD personnel</p> <p>IP-8a2: Level of compliance with MEDCOM directives for AT site</p> <p>IP-8a3: Percent of mobilized Reserve Component providers who are able to be privileged, based on the Provider Credentialing File (PCF) provided by Army Reserve Centralized Credentialing Agency (ARCCA)</p>	<p>IP-8a1: 90%</p> <p>IP-8a2: 100%</p> <p>IP-8a3: 90%</p>	<p>IP-8a1: PTMS/ Military Personnel</p> <p>IP-8a2: EPD/ Military Personnel</p> <p>IP-8a3: Credentialing Office</p>
Improve Data Quality IP-9	Improve DQ while ensuring absolute integrity in workload reporting	<p>IP-9a1: Percent of medical records in which E&M are accurately coded for the quarter</p> <p>IP-9a2: Percent of medical records in which ICD-9 are accurately coded for the quarter</p> <p>IP-9a3: Percent of medical records in which CPT are accurately coded for the quarter</p> <p>IP-9b: Percent of Point of Care audit results that meet established documentation standards</p>	<p>IP-9a1: >=97%</p> <p>IP-9a2: >=97%</p> <p>IP-9a3: >=97%</p> <p>IP-9b: 90%</p> <p>IP-9c: 96%</p> <p>IP-9d: 90%</p>	<p>IP-9a1: PAD</p> <p>IP-9a2: PAD</p> <p>IP-9a3: PAD</p> <p>IP-9b: PAD</p> <p>IP-9c: CLIN OPS</p> <p>IP-9d: CLIN OPS</p>
Robust Medical Support to AMF Mission IP-10	Project and fulfill AMF requirements by ensuring adequate staff and resources to support beneficiary population fluctuations in the Fort Riley area.	<p>IP-10a: Percent approved AMF staff positions that are filled</p> <p>IP-10b1: Number of required provider contract positions filled</p> <p>IP-10b3: Number of required technician contract positions filled</p> <p>IP-10c3: Number of required administrative contract positions filled</p> <p>IP-10d: Percent of dollars funded for required AMF facilities construction projects</p> <p>IP-10e: Ratio of enrolled beneficiaries per provider</p>	<p>IP-10a: 75%</p> <p>IP-10b1: 90%</p> <p>IP-10b2: 90%</p> <p>IP-10b3: 90%</p> <p>IP-10c: 8%</p> <p>Nil/month, 100%</p> <p>YAY, 80%</p>	<p>IP-10a: RMD</p> <p>IP-10b1: RMD</p> <p>IP-10b2: RMD</p> <p>IP-10b3: RMD</p> <p>IP-10c: Facilities</p> <p>IP-10d: DCCS/ Clin Ops</p>
Take Care of Soldiers and their families IP-11	Be the healthcare system of choice for Service Members and their families by providing high quality, accessible care.	<p>IP-11a: Percent of negative ICE comments with confirmed follow-up from provider</p> <p>IP-11b: Number of hospital tours per quarter</p> <p>IP-11c: Number of publicized public outreach/ information programs</p> <p>IP-11d: Ratio of positive versus negative ICE comments from patients</p> <p>IP-11e: Percent of preventable ER visits per month (ER visits for case-managed individuals)</p> <p>IP-11f: Percent of negative ICE comments per patients seen in the ER</p> <p>IP-11g: Average time to see a provider in the ER</p> <p>IP-11h: Percent of ER patients waiting more than 3 hours to see a provider</p> <p>IP-11i: ER Provider RVUs per FTE</p> <p>IP-11j: Percentage of similar repeated tracer findings per quarter</p> <p>IP-11k: Percentage of records containing documented patient education in AHLTA</p> <p>IP-11l: Total Tric-Care Pgms enrolled</p>	<p>IP-11a: 2/ month or 6/quarter</p> <p>IP-11c: 9 per month</p> <p>IP-11d: 20%</p> <p>IP-11e: <5%</p> <p>IP-11f: <1%</p> <p>IP-11g: <90 mins</p> <p>IP-11h: <5%</p> <p>IP-11i: TBD</p> <p>IP-11j: <5%</p> <p>IP-11k: 100%</p> <p>IP-11l: 100%</p>	<p>IP-11a: Customer Service Department</p> <p>IP-11b: PAO</p> <p>IP-11c: PAO</p> <p>IP-11d: Chief, CSD</p> <p>IP-11e: Clin Ops/ ER</p> <p>IP-11f: ER/ CSD</p> <p>IP-11g: ER</p> <p>IP-11h: ER</p> <p>IP-11i: ER/ Clin Ops</p> <p>IP-11j: Mr. Foreman/ Patient Safety</p> <p>IP-11k: DCCS/PAD</p> <p>IP-11l: Clin Ops</p>

<p>Recruit, Manage & Retain Quality AMEDD Personnel L-1</p>	<p>Recruit and retain quality IACH personnel by providing the most effective incentives, career progression, and positive work environment.</p> <p>Provide fair and equitable notification and distribution of the available inventory for deployment.</p> <p>Effectively recruit and retain a quality civilian workforce, focusing on hard-to-fill medical occupations (physician, RN, pharmacist, psychologist, social worker).</p>	<p>L-1a1: Percent reenlistment target achieved for first-term soldiers. L-1a2: Percent reenlistment target achieved for mid-term soldiers L-1a3: Percent reenlistment target achieved for career soldiers L-1a4: Percent in-service Reserve Component recruitment target achieved for separating soldiers L-1b: Percent Medical Corps ODP of ASAM III requirements L-1c: Percent of soldiers notified for deployment within 30 days of position placement L-1d1: Percent of PROFIS deployment positions filled by volunteers L-1d2: % of PROFIS Deployment Systems (PDS) fills, once locked, that are reclaimed/changed L-1a1: % of LM and higher awards received at GPRMC 150 days prior to desired presentation date L-1e2: Percent MSM award recommendations received at GPRMC 60 days prior to desired presentation date (for which it is possible to process within the available time) L-1e3: Percent of approved awards presented prior to soldiers' departures (for which it is possible to process within the available time) L-1f1: Percent OERs received on time at HQDA L-1f2: Percent of OERs mailed to HQDA NLT 60 days past "thru" date. L-1g1: Percent NCOERs received on time at HQDA L-1g2: Percent of NCOERs submitted to HQDA NLT 30 days past end of rating period. L-1h: Percent Civilian appraisals submitted on time to installation CPAC.</p>	<p>L-1a1: 100% L-1a2: 100% L-1a3: 100% L-1a4: 100% L-1b: 90% L-1c: 90% L-1d1: 5% L-1d2: <5% L-1e1: 95% L-1e2: 95% L-1e3: 95% L-1f1: 95% L-1f2: 95% L-1g1: 95% L-1g2: 95% L-1h: 95%</p>	<p>L-1a1: Retention NCO L-1a2: Retention NCO L-1a3: Retention NCO L-1a4: Retention L-1b: RMD L-1c: PTMS L-1d1: PTMS L-1d2: PTMS/ Personnel L-1a1: Military Personnel Division L-1e2: Military Personnel Division L-1e3: Military Personnel Division L-1f1: Military Personnel Division L-1f2: Military Personnel Division L-1g1: Military Personnel Division L-1g2: Military Personnel Division L-1h: RMD</p>
<p>Train & Develop AMEDD Personnel L-2</p>	<p>Provide up-to-date training of civilian and military personnel to accomplish their current responsibilities and develop skills for future positions.</p>	<p>L-2a1: Percent of annual validated training requirements integrated into IACH Command Training Guidance L-2a2: Percent IACH Soldiers having completed required training per command training guidance. L-2b1: Percent eligible soldiers having attended NCOES L-2b2: Percent eligible soldiers having attended WLC L-2b3: Percent eligible soldiers having attended BNCOC L-2b4: Percent eligible soldiers having attended ANCOG L-2b5: Percent of eligible officers having attended OBC L-2b6: Percent of eligible officers having attended CCC L-2c1: Percentage of HIPAA disclosures determined to be unauthorized L-2c2: Percentage of eligible workforce having completed required HIPAA training L-2d: Number of staff members certified as LSS Green Belts</p>	<p>L-2a1: 100% L-2a2: 90% L-2b1: >90% L-2b2: >90% L-2b3: >90% L-2b4: >90% L-2b5: >90% L-2b6: >90% L-2c1: <10% L-2c2: 90% L-2d: 1</p>	<p>L-2a1: PTMS L-2a2: EPD/PTMS L-2b1: EPD/PTMS L-2b2: EPD/PTMS L-2b3: EPD/PTMS L-2b4: EPD/PTMS L-2b5: EPD L-2b6: EPD L-2c1: PAD L-2c2: IMD L-2d: DCA</p>
<p>Train 68 CMF Personnel L-3</p>	<p>Train and develop 68 series personnel to enable confident, competent Soldiers capable of providing material support to the medical mission of healthcare providers.</p>	<p>L-3a: Quarterly lapse rate for 68 series certifications L-3b: Percentage of staffing requirements met for 68W Schoolhouse</p>	<p>L-3a: < 10% L-3b: 80%</p>	<p>L-3a: EPD L-3b: EPD</p>
<p>Forecast and Program Required Resources R-1</p>	<p>Forecast and program required resources for mission accomplishment. Accurately forecast future requirements and promote coding accuracy.</p>	<p>R-1a1: Percent Provider staff on hand as specified by the Business Plan requirements R-1a2: Percent medical staff on hand composed of Backfill R-1a3: Percent of medical staff on hand composed of contract providers R-1b1: Percent funding execution compared to straight line R-1b2: Percent funding of IACH critical AMF requirements R-1b3: Percent funding of IACH critical GWOT requirements R-1c1: Percent CEEP list filled at the end of the Fiscal Year R-1c2: Percent departments on budget target R-1c3: Percent of Super CEEP Requests filled annually</p>	<p>R-1a1: 90% R-1a2: 25% or less R-1a3: 25% or less R-1b1: +/- 5% R-1b2: 100% R-1b3: 100% R-1c1: 90% R-1c2: 100% R-1c3: 100%</p>	<p>R-1a1: RMD R-1a2: Personnel R-1a3: RMD R-1b1: RMD R-1b2: RMD R-1b3: RMD R-1c1: Logistics R-1c2: RMD R-1c3: Logistics</p>
<p>Effective Financial Stewardship R-2</p>	<p>Ensure current and future resource allocation decisions provide the best return on investment in support of the IACH strategic direction. Identify and implement best clinical and business practices by emphasizing process improvements and the optimization of Uniform Business Offices' operations. Operate within budget without cost shifting to purchased care or other payers.</p>	<p>R-2a: Cost/RWP R-2b: Cost/APG R-2c1: Prime Vendor usage rate. R-2c2: Prime Vendor bill rate. R-2c3: Percent reduction in government IMPAC credit card use for med/surg supplies from last FY R-2d4: Percent government travel card bills delinquent over 60 days R-2e5: Percent of financial liability investigations completed in 75 days R-2d1a: Obligation rate for Civilian pay. R-2d1b: Obligation rate for travel R-2d1c: Obligation rate for contracts R-2d1d: Obligation rate for supplies R-2d1e: Obligation rate for Pharmacy R-2d1f: Obligation rate for equipment R-2d1g: Obligation rate for other elements of resource. R-2d2: burn rate (adjusted for front loaded contracts) as compared to straight line projection.) R-2d3: Percent deviation (plus or minus) from FY 06 burn rate</p>	<p>R-2a: \$108 R-2b: 70% R-2c1: 90% R-2c2: 10% R-2c3: 10% R-2d4: <= 1.5% R-2e5: 100% on time R-2d1a: +/- 5% R-2d1b: +/- 5% R-2d1c: +/- 5% R-2d1d: +/- 5% R-2d1e: +/- 5% R-2d1f: +/- 5% R-2d1g: +/- 5% R-2d2: +/- 5% R-2d3: +/- 5%</p>	<p>R-2a: DCA R-2b: DCA R-2c1: DCA/ Logistics R-2c2: DCA/ Logistics R-2c3: Logistics R-2d4: RMD R-2e5: DCA/Logistics R-2d1a: RMD R-2d1b: RMD R-2d1c: RMD R-2d1d: RMD R-2d1e: RMD R-2d1f: RMD R-2d1g: RMD R-2d2: RMD/ DCA R-2d3: RMD/ DCA</p>
<p>Allocate Resources Strategically R-3</p>	<p>Serve as effective financial stewards by making sound fiscal decisions in the best interest of IACH, AMEDD, the Army, and American taxpayers. Instill in IACH leaders a mindset of financial accountability, so our spending is producing the desired results.</p>	<p>R-3a1: Percent Inpatient RWP MARKET SHARE (05Q4) R-3a2: Inpatient RWP productivity targets achieved as prescribed by Business Plans R-3b1: Percent Outpatient RVU MARKET SHARE R-3b2: Outpatient RVU productivity targets achieved as prescribed by Business Plans R-3c1: Total RWUs R-3c2: Total RVUs R-3d1: Number of bed days per thousand enrollees R-3d2: Cost for prime enrollees per member per month R-3d3: Enrollee purchase care costs R-3d4: Preventable admission rates for active duty enrollees R-3d5: Preventable admission rates for non-active duty enrollees R-3e1: MEPRS: Percent of facilities reporting R-3e2: MEPRS: Percent of facilities reporting by suspense date</p>	<p>R-3a1: 48.6% R-3a2: 9.072 R-3b1: 63.37% R-3b2: 85.7294 R-3c1: 558.96 R-3c2: 9.3097 R-3d1: 200 R-3d2: \$257 R-3d3: TBD R-3d4: <= 3.51% R-3d5: <= 7.07% R-3e1: 90% R-3e2: 90%</p>	<p>R-3a1: RMD/Clin Ops R-3a2: RMD/Clin Ops R-3b1: RMD/Clin Ops R-3b2: RMD/Clin Ops R-3c1: Clin Ops R-3c2: Clin Ops R-3d1: Clin Ops R-3d2: Clin Ops R-3d3: Clin Ops R-3d4: Clin Ops R-3d5: Clin Ops R-3e1: Clin Ops R-3e2: Clin Ops</p>